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## Monterey, California



## THESIS

**AN EVALUATION OF RESOURCE SHARING  
WITHIN TRICARE'S  
MANAGED CARE SUPPORT CONTRACTS**

by

Martin D. McCue

September, 1996

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**AN EVALUATION OF RESOURCE SHARING  
WITHIN TRICARE'S  
MANAGED CARE SUPPORT CONTRACTS**

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Submitted in partial fulfillment  
of the requirements for the degree of

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from the

**NAVAL POSTGRADUATE SCHOOL**

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## **ABSTRACT**

To help reduce the overall cost of health care in the Military Health Services System, Managed Care Support Contracts include a provision known as Resource Sharing. Resource Sharing Agreements allow the contractor to provide personnel, equipment, or supplies to a military treatment facility to improve its capability to deliver health care. After reviewing civilian managed care programs, this thesis examines the Military Health Services System and its new managed care program known as TRICARE. Then the concept of Resource Sharing is examined and the process for identifying, evaluating, and using cost-effective Resource Sharing Agreements is discussed. Case studies of different types of agreements are used to illustrate the complexity and importance of cost and workload estimates and key contract factors in understanding the agreements. The findings suggest that the contractor's and government's performance data and assumptions underlying the agreements should be continuously monitored to ensure the cost-effectiveness of the agreements.





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## **I. INTRODUCTION**

### **A. BACKGROUND**

The Military Health Services System (MHSS) is one of the nation's largest health care systems, offering health benefits to about 8.3 million people and costing over \$15 billion annually. Its primary mission is to maintain the health of 1.7 million active duty service personnel and to be prepared to deliver health care during times of war. Also, as an employer, the Department of Defense (DOD) offers health care services to 6.6 million nonactive-duty beneficiaries. These services are provided through a system of medical centers, smaller hospitals, and clinics worldwide, and through a DOD administered insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). (GAO Report, 1995)

Like the civilian marketplace, the United States uniformed services are reforming their health care system. This is due in large part to DOD experiencing many of the same challenges facing the national health care system such as, increasing costs, uneven access to health care services, and disparate benefit and cost sharing packages for similarly situated categories of beneficiaries. In response to these challenges, DOD initiated, with Congressional authority, a series of demonstration programs around the country designed to explore various alternatives by which it could more effectively manage the care it provides and funds (GAO Report, 1995). These demonstration projects led DOD, in 1993, to begin a nationwide managed care program, called TRICARE.

The TRICARE program was developed to ensure the most effective execution of the military health care mission, ensure access to a quality health care benefit, control health care costs, and respond to rapidly changing military and national health care priorities (Lamar, 1994). The program is specifically designed to assist military treatment facility commanders in optimizing their resources in providing comprehensive health care coverage to eligible beneficiaries. The program is being implemented nationwide in twelve Health Service Regions (HSR). Each region will have a Lead Agent Military Treatment Facility/Commander. Lead Agents will communicate and work in concert with the regional MTF commanders, as well as Service headquarters' staff and Office of the Assistant Secretary of Defense for Health Affairs OASD(HA) to support the Military Health Services System (MHSS) mission (OASD(HA), 1995). At the heart of TRICARE are the Managed Care Support Contracts (MCSC) for each region. The MCSC contracts are centrally procured by the TRICARE Support Office (TSO). The MCSC supplements the capabilities of the MTF through the establishment of civilian provider networks.

In an effort to reduce overall government cost of health care under this MCSC a feature was placed in the contract which allows the government to enter into Resource Sharing Agreements (RSAs) with the contractor. This provision, known as Resource Sharing (RS), allows the contractor and MTF to work together in improving the utilization of the MTF's resources and recapturing TRICARE workload, previously known as CHAMPUS.



## **B. OBJECTIVES OF THE THESIS**

This thesis involves the evaluation of Resource Sharing Agreements (RSA) as they are now used under the MCSC. It will entail an analysis and comparison of how RSAs are identified, evaluated, and implemented in accordance with current policy through the use of case study examples of actual RSAs. It will provide the reader with a thorough understanding of RSAs and their role in optimizing MTF utilization and decreasing TRICARE/CHAMPUS costs. Specifically, this thesis will describe the process for developing an RSA with emphasis on information requirements, sources of data, and determining cost-effectiveness through the use of the Financial Analysis Worksheet. The reader should have a good understanding of this worksheet and how the selected inputs affect the overall outcome.

## **C. RESEARCH QUESTIONS**

This thesis will examine how RSAs are being utilized within the MHSS by the MTFs and the Managed Care Support Contractor and how these agreements are evaluated for cost-effectiveness. The primary research question addresses the following: What is the current process for identifying, evaluating, and utilizing RSAs and how do RSAs affect the costs of the Managed Care Support Contract?. In addition to the primary research question, four subsidiary questions will be answered. Specifically, they are:

- What are the roles of the MTF, Contractor, and Lead Agent in the RSA process?
- What are the key factors and assumptions utilized in the Financial Analysis Worksheet when evaluating an RSA for cost-effectiveness?
- What is meant by “workload credit” and how does this concept affect the Managed Care Support Contract costs?

- What are the key differences in the types of RSAs and how they affect the evaluation process?

#### **D. DELIMITATIONS**

Due to the newness of the MCSCs there was not a lot of data on RSAs and time did not permit an exhaustive survey of actual practices. Therefore, this thesis will focus on disguised examples of RSAs from specific regions within the MHSS. The case examples are representative of the factors and issues that impact RSAs. While the policies and procedures are the same for implementing RSAs across all of the regions, the potential uses may differ across regions as a result of different managed care support contractors, size of MTFs, location, enrolled population, and civilian provider's experience with managed care. In addition, due to the recent development of this concept, methods are continually being refined for evaluating RSAs by OASD(HA) and support staff. This thesis will concentrate on the methods and experiences used by the Health Service Regions at the time of evaluation.

#### **E. SCOPE OF THESIS**

This thesis will examine the feature in the Managed Care Support Contract known as Resource Sharing through an extensive literature review, and analysis and comparison of RSAs through case study examples. It will focus on the development of RSAs and the role of the MTF, Contractor, and Lead Agent in this process. Emphasis will be placed on the evaluation of RSAs for cost-effectiveness to the government and the contractor. We will provide an indepth examination of the Financial Analysis Worksheet (FAW) and the critical factors which make it up.

## **F. METHODOLOGY**

To provide the background information on practices and policies for using RSAs we will examine the existing literature on RSAs from the OASD(HA), Kennell and Associates, various Lead Agent briefings, and the managed care support contracts. Personal interviews will also be conducted with key personnel at OASD(HA), Kennell and Associates (an OASD(HA) contractor), the Lead Agent, and the MCS contractor to gain their insight and perspective into the current policy and use of RSAs. Actual field visits will be made to Kennell and Associates and the Lead Agent to collect the necessary data and information for this study. Because of the recent implementation of RSAs it was not possible to use questionnaires or surveys for this research.

## **G. ORGANIZATION OF THESIS**

This thesis is composed of five chapters. This chapter provides the introduction, which includes the background and a basic overview of the subject matter, the objectives, research questions, scope and methodology that will be used to address the research questions. Chapter II provides a background on the MHSS, civilian managed care programs, and the TRICARE/CHAMPUS program. Chapter III describes RSAs under Department of Defense, Health Affairs and the MCS Contract policy. Chapter IV discusses the application of RSAs using sample case studies. Chapter V provides discussion, the summary, conclusions, and recommendations.



## **II. BACKGROUND**

This Chapter will focus on civilian managed care programs, background of the Military Health Services System, and the DOD's managed health care program known as TRICARE.

### **A. CIVILIAN MANAGED CARE PROGRAMS**

The first "managed care" programs can be traced to health maintenance organizations (HMO), previously known as prepaid group practice plans. An HMO is a formally organized system that integrates the delivery and financing of health care services. It provides a comprehensive range of services through designated providers to an enrolled population, usually for a prepaid fixed price. The HMO concept stresses a close relationship among patients and their physician that provides incentive to both parties to minimize expensive medical treatment. In an HMO emphasis is placed on preventive care as opposed to acute care, which is emphasized under the traditional fee for service insurance (Borglum, 1994). An estimated 50 million Americans received care through health maintenance organizations (HMO) in 1994. This was an increase of 5 million over the previous year and an increase of 21.5 million over the number of HMO members in 1986, according to the Group Health Association of America (GHAA). GHAA expects HMO coverage to reach 56 million Americans in 1995.

Preferred Provider Organizations (PPO) are another managed care type plan. PPOs are slightly different than HMOs. A PPO is a managed care plan which contracts with a select group of participating providers. Typically, participating providers in PPOs agree to abide

by utilization management criteria and agree to accept the PPO's reimbursement structure and payment levels. PPO coverage typically permits members to use non-PPO providers, although higher levels of coinsurance or deductibles apply to services provided by these non-participating providers. (Borlum, 1994)

Health Services Organizations (HSO) that provide "managed care" are commonly called "managed care plans." Managed care plans are characterized by the following:

- Offer one or more products that integrate financing and management with delivery of health services to an enrolled population
- Are responsible for delivering services (using their HSO or through contractual arrangements) and (as network or as individual providers) either share financial risk and/or have some incentive to deliver efficient services
- Use an information system capable of monitoring and evaluating patterns of utilization and financial outlays (Hale, 1988)

Another element of managed care that has greatly influenced the DOD is capitation. Capitation is a method of reimbursement where a fixed amount of payment per patient, per period of time is paid to a health care provider. Capitation is usually expressed in units of per member per month and may be varied by such factors as the age and sex of the enrolled member. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the condition of the provider contract. (Borlum, 1994)

The concept of capitation is an important strategy for containing the cost of health care. Under a capitation system, the provider assumes responsibility for providing health services to a defined population, for a fixed amount per beneficiary regardless of the amount

of health services used. There is no financial incentive under a capitation methodology to inappropriately increase the number of services or to provide more costly care than is clinically appropriate. Because a capitated allocation system makes the provider responsible for providing all health services, there are built in incentives for care to be provided in the most cost effective setting--the use of preventive services, the efficient delivery of each episode of care, and the careful monitoring of the volume of provided services. Capitation discourages inappropriate hospital admissions, excessive lengths of stay, and unnecessary services.

These developments in the civilian health care industry motivated DOD officials to pursue some of these innovative approaches to health care delivery in reforming DOD Health Care.

## **B. MILITARY HEALTH SERVICES SYSTEM**

The MHSS Strategic Plan defines the MHSS mission as follows,

*To provide top quality health services, wherever needed in support of military operations, and to members of the Armed Forces, their families, and others entitled to DOD health care.*

As the mission statement reveals the MHSS has a dual mission, the wartime readiness mission and the peacetime benefit mission. The current readiness mission consists of ensuring that military medicine is prepared to provide support for two major regional conflicts, contingency operations, police actions, humanitarian efforts, or disaster relief. The peacetime benefit mission consists of providing health care to all eligible beneficiaries: active duty members, active duty family members, retirees, and retiree family members. The MHSS does

not have the personnel or MTF capacity to meet both of these missions simultaneously. As a result the MHSS is made up of two components, the direct care system and the indirect care system known as the TRICARE program.

### **1. Direct Care System**

The direct care system of the MHSS consists of over 600 military treatment facilities including 127 military hospitals and 504 clinics. These facilities take care of the active duty population, and if “space” permits the care of active duty family members, retirees and their family members. In addition, these facilities provide the training ground to ensure that military medical personnel are capable to perform their readiness mission.

To gain a better understanding of how the direct care system works a little more background information is needed on eligibility and the process for using military treatment facilities. Eligibility for care is determined through the use of the Defense Enrollment Eligibility System (DEERS). All beneficiaries must be enrolled in DEERS in order to receive care in military treatment facilities, or to have claims processed through TRICARE.

Active duty individuals have first priority at all MTFs. They receive free medical care, including hospitalization, pharmaceuticals, immunizations, regular physical examinations and dental care. As a result of the new TRICARE program the priority system for care of others at MTFs has changed. In the past the order was active duty, active duty family members, retirees and their family members. Under the TRICARE program active duty still remain first priority, second priority goes to active duty family members or retirees and their family members who are participants in the TRICARE Prime option. Priority then goes to active duty family members not enrolled in Prime and last priority goes to retirees and their family



members respectively. There is no cost to beneficiaries seen in the MTF as an outpatient and only meal charges are assessed for non-active duty inpatients.

MTF commanders are responsible for the delivery of health care to all eligible beneficiaries within their catchment area. The catchment area is defined as the 40 mile radius of an MTF. Eligible beneficiaries that reside in an MTF's catchment area must use that MTF for nonemergency inpatient care and 14 outpatient care procedures. If your designated MTF cannot provide the inpatient or outpatient care a nonavailability statement (NAS) is issued. A NAS is a certification from an MTF stating that the care is necessary and cannot be provided by the MTF. This statement authorizes the beneficiary to receive care under the TRICARE/CHAMPUS program. Beneficiaries must have a nonavailability statement prior to receiving care at a civilian treatment facility, otherwise TRICARE/CHAMPUS may not share in the cost.

Taking care of family members in MTFs assists in meeting the MHSS readiness requirements. Since the active duty population is relatively healthy and the MTF is DOD's peacetime medical training ground it is imperative that military providers experience an adequate case-mix of medical procedures to maintain and improve their skills. In the direct care system there is an overlap of both the readiness and benefit mission. However, MHSS capacity does not meet the entire peacetime benefit mission so the indirect care system was developed to bridge the gap between MTF capacity and beneficiary requirements.

## **2. Indirect Care System**

The origins of military medical care for the families of active duty members of the uniformed services dates back to the late 1700s. The following statement supports the early

policy: "Medical Officers of the Army and contract surgeons shall whenever practicable attend the families of the officers and soldiers free of charge." (Army Appropriations Act, 1884). There was very little change in this policy until World War II. Most draftees in that war were young men who had wives of child-bearing age. The military medical care system, which was on a wartime footing, couldn't handle the large number of births, nor the care of very young children.

In 1943, Congress authorized the Emergency Maternal and Infant Care Program (EMIC). EMIC provided for maternity care and the care of infants up to one year of age for wives and children of service members in the lower pay grades. It was administered by the "Children's Bureau" through state health departments. (OCHAMPUS, 1996)

The Korean conflict again strained the capabilities of the military health care system. In 1956, the Dependents Medical Care Act was signed into law, effective Dec. 7, 1956. The 1966 amendments to this act created the current CHAMPUS program, authorizing ambulatory and psychiatric care for active duty family members, effective October 1, 1966. Retirees, their family members, and certain surviving family members were brought into the program on January 1, 1967. (OCHAMPUS, 1996) The CHAMPUS program was basically an indemnity insurance program similar to traditional fee-for-service plans. As a result non-active duty beneficiaries were eligible to receive care from civilian providers and to cost share the cost of that care with the DOD through the CHAMPUS program.

The CHAMPUS budget for Fiscal Year 1967 was \$106 million. Records don't indicate how many claims were filed in 1967, but the total probably wasn't more than a few thousand. In FY 1994, the CHAMPUS budget was more than \$3.5 billion, and more than 20

million claims were received. Today, nearly 5.7 million people are eligible for CHAMPUS/TRICARE benefits. (OCHAMPUS, 1996)

In the 1980s, the search for ways to improve access to top quality medical care, while keeping costs under control, led to several CHAMPUS "demonstration" projects in various parts of the U.S. (OCHAMPUS, 1996) The projects included the CHAMPUS Reform Initiative (CRI) in California and Hawaii, the Catchment Area Management program in Charleston, South Carolina, and the TRICARE Demonstration project in Tidewater, Virginia. After evaluating the results of these programs DOD designed TRICARE, a managed care program offering beneficiaries alternatives to the fee-for-service program under CHAMPUS.

### **C. DOD's MANAGED CARE PROGRAM (TRICARE)**

#### **1. Overview**

TRICARE is the DOD managed care program for members of the uniformed services and their families, and survivors and retirees and their families. The TRICARE Program brings the direct care and indirect care system together in a cooperative and supportive effort to provide access and quality care to military beneficiaries and make optimal use of the limited resources available to military medicine. This cooperative effort restructures the MHSS into 12 Health Service Regions with each region designated a Lead Agent MTF/Commander.

#### **2. Lead Agent**

The Lead Agent serves as the focal point for health services and coordinates with all of the MTFs within their respective region and the Managed Care Support contractor to develop an integrated health care delivery plan for their beneficiaries. The regions were established to ensure an adequate beneficiary population base to support cost-effective

volumes of care under the TRICARE support contracts, and regional access to tertiary care provided primarily by medical centers (OASD(HA), 1996). Specific responsibilities of the Lead Agent include:

- Develop Regional Health Services Plan
- Develop contract requirements for region
- Coordinate patient referrals/Non-availability statements
- Ensure optimal resource utilization throughout the region (includes Resource Sharing)
- Support contingency plans for continuation of clinical services
- Approve referral processes within the network
- Support optimal use of MTF resources
- Recommend designation of regional Specialized Treatment Services
- Develop evaluation plans for managed care goals (Parish, 1995)

OASD(HA) policy states that the health care system will be monitored by the Military Departments and OASD(HA). However, health care is delivered locally; therefore, it must be managed locally. MTF Commanders will be given the tools, flexibility and authority to make appropriate decisions about the delivery of care. In addition, MTF Commanders and Lead Agents are accountable for the health care costs, quality and access in their delivery areas for all beneficiaries, in both the civilian networks and the direct care system.

### **3. Triple Option Benefit**

TRICARE provides beneficiaries with three choices for their health care delivery: TRICARE Standard, a fee-for-service option previously known as CHAMPUS; TRICARE Extra, which offers a preferred provider option (PPO) with discounts; and TRICARE Prime, an enrolled health maintenance option (HMO). TRICARE Prime is the Uniform HMO Benefit mandated by Section 731 of the National Defense Authorization Act for Fiscal Year 1994. This mandate required that the Uniform HMO Benefit option be "to the maximum extent possible" incorporated in "all future managed health care initiatives undertaken by DOD." The option is required to provide reduced out-of-pocket expenses for the beneficiary and a benefit structure that is as uniform throughout the United States.

The statute further required a determination that, in the particular managed care initiative that contains the Uniform HMO Benefit, DOD costs "are not greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the option." The TRICARE final rule on establishing and implementing this uniform benefit was published in the Federal Register on October 5, 1995. All of the stipulations above must now be incorporated in managed care initiatives and the Uniform HMO Benefit will replace the benefit currently offered in our various managed care programs.

### **4. DOD Modified Capitation Methodology**

The Department of Defense, Health Affairs uses a modified capitation methodology that is based upon the MHSS user population as opposed to the traditional capitation model which is based on a specific number of enrollees. Through this model OASD(HA) allocates resources to the three Services from Defense Health Program funds.

The three Services then allocate funds to MTFs based on the eligible beneficiary population.

Resource allocations are based upon a two-step process that reflects each Service's individual requirements yet is consistent with the overall Defense Health Program resource allocation framework. The Military Departments allocate resources to each of their MTFs based on the modified capitation methodology, designed by the Services to meet their unique requirements as approved by Health Affairs. The Military Departments identify all CHAMPUS resources for the Lead Agent's management oversight at each of the twelve regions. The method for further allocating the CHAMPUS resources will be dependent on the Service affiliation of the regional Lead Agent and the existence of a fixed price, at-risk managed care support contract. Calculation of the allocation of CHAMPUS resources to MTFs in regions with such contracts is made by Health Affairs and provided to the Military Departments. (OASD(HA), 1996)

In regions with TRICARE managed support contracts, the MTF's TRICARE/CHAMPUS allocation will be retained by the parent Services and pooled among the Services to fund Lead Agent's execution of the support contract. Health Affairs will calculate both catchment area and out of catchment area TRICARE/CHAMPUS allocations and provide them to the Military Departments.

Under this methodology, each Service remains accountable for the TRICARE managed care support contract. (OASD (HA), 1996)

## **5. Managed Care Support Contracts**

A major component of TRICARE is the Managed Care Support Contracts (MCSC) that supplement the capabilities of the regional MTF health care delivery networks. These contracts are procured centrally by the TRICARE Support Office and will assist the Lead Agents and MTFs in meeting their responsibilities to improve access to quality health care, while containing costs. Seven fixed-price, at-risk contracts will be awarded in support of the twelve Health Service Regions. The contracts for Regions 3, 4, 6, 7, 8, 9, 10, 11, 12 have been awarded and the estimated award dates for Region 1 is August 1997, Region 2 September 1997, Region 5 September 1997. The primary functions of the support contracts according to OASD(HA) are:

- Development of civilian provider networks in support of both the TRICARE Prime and TRICARE Extra benefits
- Claims processing and data collection
- Utilization management and quality assurance
- Patient routing and referral, and beneficiary services
- TRICARE Prime program enrollment
- Provider and beneficiary education
- Marketing
- Resource Sharing/Resource Support

The key concept associated with the managed care support contracts is that the Services and hence the Federal government will share in the financial risk for the TRICARE

program. In a truly capitated environment the contractor would receive a specified dollar amount for each enrolled member. However, in the MHSS case there is an existing direct health care system that is going to be augmented by the managed care support contractor. As a result of the unique military environment it is not possible to set a fixed capitated rate for the health care portion of the MCSC. A variety of factors preclude this, such as, the changing beneficiary population due to permanent change of station (PCS) orders, reduction in force and BRAC initiatives, and lastly the vast size of the DOD health care system which makes it impossible to change the entire CHAMPUS system from a basic fee-for-service indemnity plan to an HMO all at once for all beneficiaries. As a result, in the MCSC the administrative portion of the contract and the profit thereon is fixed, while the health care costs are subject to adjustments via a bid price adjustment process. The profit on health care is fixed, however, it may be reduced or lost through the risk sharing provisions. The resulting gains or losses incurred by the contractor are then shared with the government based on the risk sharing provisions in the contract. The bid price adjustment process and risk sharing provisions will be discussed in Chapter III.

The managed care support contracts (MCSC) provide substantial incentives for the contractor to partner with the MTF in keeping health care costs down. One method of partnership is through the use of Resource Sharing Agreements (RSA). Chapter III discusses this concept of Resource Sharing.

## **6. Future Changes in Financing TRICARE**

A new revised financing method for allocating funds is being explored and may be implemented in future managed care support contracts for Region 1 and possibly Regions 2



and 5. Under this approach, the MTF will receive TRICARE funds in advance for those TRICARE eligibles who enroll in Prime with an MTF Primary Care Manager (PCM), and the MTF will have sole financial responsibility and risk for these TRICARE eligibles (i.e., the MCS contractor will not be at risk for the MTF Prime enrollees). For any civilian care required for the MTF Prime enrollees, the MTF will pay the contractor at the individual network provider rates (i.e., discounted). The contractor will track those claims paid for the MTF's Prime enrollees separately from other TRICARE claims, and the MTF will reimburse the contractor on a monthly basis after receiving a report from the contractor documenting the claims paid for MTF Prime enrollees. The contractor will continue to be at risk for all other CHAMPUS eligibles (those who enroll in Prime with civilian PCMs and all beneficiaries in Extra and Standard), with bid price adjustments and risk sharing provisions applicable only to these non-MTF Prime enrollees. (OASD (HA), 1996) The bid price adjustment and risk sharing provisions will be discussed in Chapter III.



### III. OVERVIEW OF BID PRICE AND RESOURCE SHARING AGREEMENTS

#### A. GENERAL

Resource Sharing Agreements (RSAs) are a feature in the MCSC which allow the contractor, through agreements with MTF Commanders, to provide personnel, equipment, and supplies to MTFs for the purpose of enhancing the MTF's capability of providing needed inpatient and outpatient care to beneficiaries (Montgomery, 1994). There are two types of RSAs, internal and external. These two types of agreements fall into one of three categories: a new service that recaptures CHAMPUS workload, replacement of an existing MTF service whose workload was counted in the data collection period (DCP) or new workload that was not counted in the DCP (cost avoidance), and a Partnership conversion that existed in the DCP.

The contractor's original bid price is based on information supplied by the government that includes CHAMPUS Costs, CHAMPUS and MTF utilization (without resource sharing), CHAMPUS inflation/deflation, and numbers of eligible beneficiaries during the twelve months prior to the start of health care delivery under the contract. This period is referred to as the "data collection period" (DCP) or the "base period".

Internal Resource Sharing is designed to enhance the MTF capability to treat patients through the augmentation of staff, equipment, or supplies by the managed care support contractor, thereby recapturing TRICARE patients and realizing savings for the government (Brock, 1996).

External Resource Sharing involves MTF physicians or other health care professionals providing care to CHAMPUS eligibles in a civilian health care facility. In this type of agreement the contractor avoids paying the professional's fee and only pays for the facility charges under CHAMPUS. The avoidance of professional charges should create a gain to be shared by the government and the contractor. In the chapter we will discuss the key elements of the MCSC that are affected by the use of RSAs and the process involved with establishing an RSA.

## **B. KEY ELEMENTS AFFECTED BY RESOURCE SHARING AGREEMENTS**

### **1. Bid Price/Bid Price Adjustment**

The contractor's bid price is composed of three elements: fixed administrative costs, fixed profit on administrative costs and health care costs, and expected health care costs. The expected health care costs to be incurred by the MCS contractor are composed of eight categories; three inpatient, four outpatient, and a category for other costs:

- Category 1 Inpatient Medical/Surgery
- Category 2 Inpatient OB/GYN
- Category 3 Inpatient Psychiatry
- Category 4 Outpatient Medical/Surgery
- Category 5 Outpatient Psychiatry
- Category 6 Outpatient Lab/X-ray
- Category 7 Outpatient Other (includes Pharmacy)
- Category 8 Resource Sharing, DRG Capital and Medical Education

The health care costs for categories 1-7 are used in the bid price formula and are broken down by active duty dependent (ADD) and non-active duty dependent (NADD) and the type of plan (i.e., prime, extra, standard) for each option period. Category 8 expenditures are added to the bid price for the entire Region.

As mentioned earlier the contractor's original bid price is based on information supplied by the government. Government provided information consists of CHAMPUS Costs, CHAMPUS and MTF utilization (without resource sharing), CHAMPUS inflation/deflation, and numbers of eligible beneficiaries during the twelve months prior to the start of health care delivery under the contract. The government also supplies the contractor with estimates of key components of the DCP information and projections of CHAMPUS inflation rates for each of the five one year option periods for health care delivery.

In developing their price proposals, the bidders are required by the government to project changes in CHAMPUS costs for each option period based on their own assumptions of how well they can market their program and manage the health care of the beneficiary population.

The expected health care costs are the portion of the contract that is subject to bid price adjustment. Four factors influence the bid price adjustment:

- changes from the data collection period (DCP)
- changes in ADD and NADD CHAMPUS eligible beneficiaries
- changes in MTF utilization levels and inpatient case mix
- changes in inflation, and risk sharing

The administrative cost and profit thereon are not subject to bid price adjustment.

The bid price adjustment process proceeds through a series of events that begin with the bidder being awarded the contract based on his best and final offer (BAFO) using the DCP information. The first two adjustments use revised DCP data which establishes a baseline from which the health care services cost are measured. The first adjustment occurs seven months into the first option year of health care delivery when better DCP estimates are available. Adjustments are made due to changes in estimates of MTF utilization, inflation/deflation factors, and beneficiary population. Seven months into option period 2 and 19 months after health care delivery begins, a final estimate of the DCP data is used for an adjustment of the health care costs for each of the five option years.

Subsequent to this, two adjustments take place for each option period where the cost from the adjustment are compared to the contractor's actual costs. The resulting gain or loss may be shared between the contractor and the government according to the risk sharing provisions of the contract. Table 1 on page 25 provides a schedule of Bid Price Adjustments as required by the contract.

<b>Time of Adjustment</b>	<b>Adjustments Made</b>
7th Month of Option Period 1	Initial DCP Changes
7th Month of Option Period 2	Final DCP Changes Initial Option Period 1 Changes
7th Month of Option Period 3	Final Option Period 1 Changes Initial Option Period 2 Changes
7th Month of Option Period 4	Final Option Period 2 Changes Initial Option Period 3 Changes
7th Month of Option Period 5	Final Option Period 3 Changes Initial Option Period 4 Changes
7th Month after Option Period 5	Final Option Period 4 Changes Initial Option Period 5 Changes
13th Month after Option Period 5	Final Option Period 5 Changes

Table 1. Schedule of Bid Price Adjustments

*a. Components of Bid Price Associated with RSAs*

In addition to the above, the bid prices for each of the contract option periods are directly influenced by a series of ratios bid by the contractor. Two of these are of critical importance in relationship to resource sharing: the “O” factor for changes in MTF utilization, and the “resource sharing trend factor” (Montgomery, 1994).

(1) “O” Factor for MTF Utilization. The “O” factor addresses adjustments in MTF utilization and is calculated for both inpatient costs, Category 1-3, and outpatient costs, Category 4-7. The “O” factor is set at 1.00 if there are no changes in MTF utilization from the DCP. For a specific option period if the value is greater than 1.00, then

MTF utilization is expected to decrease. This means relatively more care is going to be provided by the contractor thereby increasing the health care costs for the contractor which the government must pay. If the value is less than 1.00, then MTF utilization is expected to increase. In this situation the MTF is recapturing workload that was previously done by the contractor thereby decreasing the contractor's cost.

The "O" factor for inpatient care is based on the ratio of nonavailability statements (NASs) per eligible issued by MTFs in the option period, compared with the ratio for the DCP data. For outpatient care it is based on changes in the ratio of outpatient visits per eligible non active duty personnel, compared with the ratio for the DCP data and the volume trade off factor (VTF).

The volume trade off factor (VTF) reflects that changes in outpatient MTF utilization do not always result in equal and opposite changes in CHAMPUS utilization. This is due in part to a variety of factors such as: MTF care is free and there are cost shares associated with TRICARE, individuals may have private health insurance, or individuals may decide not to be treated. So the VTF assumes that demand for outpatient health care in the MTF is greater than demand for care under TRICARE. For example, a volume trade off factor of 2.0 implies that 2.0 unit increase in MTF workload constitutes a 1.0 unit decrease in TRICARE/CHAMPUS workload. Volume trade off factors are bid separately for both active duty dependent (ADD) and non active duty dependent (NADD) since they may be different. The "O" factor for inpatient care is calculated as follows:

$$O = (N_o/N_b) \times N\% + \text{non}N\% \quad \text{where,}$$

$N_o$  = ratio of NASs per eligible in option period



Nb = ratio of NASs per eligible in base period

N% = proportion of CHAMPUS costs requiring an NAS (i.e., 55%)

nonN% = proportion of CHAMPUS costs not requiring an NAS (i.e., 45%)

As mentioned above the Bid Price Adjustment is directly influenced by changes in MTF utilization which is represented by the "O" factor in the bid price formula. The following is an example of how the inpatient "O" factor is calculated. Assume the ratio of NASs per eligible in the DCP is .100, and the ratio is projected to be .102 for the first option period. If the DCP data indicates that 60% of inpatient TRICARE/CHAMPUS costs require an NAS (N%), the resulting inpatient "O" factor for the first option period (Op), is computed as follows:

$$Op = (.102/.100) \times .60 + .40 = 1.012 \quad \text{projected "O" factor}$$

If, after the option period (19th month BPA), the final ratio of NASs per eligible issued in the DCP is .098 instead of .102 which had been initially projected, the resulting actual "O" factor for the region in the first option period (Oa) is:

$$Oa = (.098/.100) \times .60 + .40 = .988 \quad \text{actual "O" factor}$$

Thus, the ratio of the actual "O" factor (Oa) to the projected "O" factor (Op) used in the bid price adjustment formula for that option period is:

$$(Oa/Op) = (.988/1.012) = .976$$

If all other factors in the bid price formula do not change, this ratio results in all inpatient costs being adjusted downward by a factor of .024 or 2.4%. (Montgomery, 1994)

The outpatient "O" factor is calculated using the formula:

$$O = [Cb + (Mb - Mo)/VTF]/Cb \quad \text{where,}$$

Cb = the ratio of CHAMPUS outpatient visits per CHAMPUS eligible beneficiary in the DCP

Mb = the ratio of non active duty MTF outpatient visits per CHAMPUS eligible beneficiary during the DCP

Mo = the ratio of non active duty MTF outpatient visits per CHAMPUS eligible beneficiary during the option period

VTF = the volume trade off factor for outpatient care

For example, in the DCP (the base period) the ratio of NADD MTF CHAMPUS outpatient visits per CHAMPUS eligible is 2.00 (Cb) and the ratio of NADD MTF outpatient visits per CHAMPUS eligible is 4.00 (Mb). Also assume the ratio of NADD MTF outpatient visits per CHAMPUS eligible during an option period (Mo) is initially projected to be 3.80 in the seventh month following the end of the option period and further assume that the volume trade off factor is 1.8. The projected "O" factor (Op) is calculated as follows:

$$Op = [2.0 + (4.00 - 3.80)/1.8]/2.0 = 1.06 \quad \text{projected "O" factor}$$

This ratio indicates that, all other factors being equal, all outpatient cost projections for the option period (for the NADD category of beneficiary) would be increased by ten percent when compared with the costs applicable to the DCP or "base period".

If, 19 months after the option period, the actual ratio of outpatient visits per CHAMPUS eligible provided by the MTF to non active duty beneficiaries was 3.60, instead of the projected 3.80, the actual "O" factor (Oa) for the option period is completed as follows:

$$Oa = [2.00 + (4.00 - 3.60)/1.8]/2.00 = 1.11 \quad \text{actual "O" factor}$$

Therefore, all projected outpatient costs would be multiplied, in the bid price adjustment formula, by the ratio:

$$Oa/Op = 1.11/1.06 = 1.048$$

If all other factors in the bid price formula do not change, this ratio results in a 4.8% increase in outpatient costs in the bid price adjustment.

***b. Impact of Workload***

The above are examples of calculating the “O” factor without taking into consideration workload attributable to resource sharing. The contractor may be given full “workload credit” for RSAs or a percentage less than 100%. The workload in question takes place in the MTF. The “credit” to the contractor is actually an offset to MTF workload to ensure there are no dis-incentives for the contractor to do resource sharing. If the contractor is given full “workload credit” for the RSA this workload is counted just as if the patients being seen in the MTF under the agreement were being seen in the civilian network. Since the contractor has already reflected savings to the government in the reduced bid price, it is appropriate to give the contractor full credit for workload under resource sharing until the point where the contractor has spent the amount set forth in the bid for Category 8 resource sharing. Once the contractor has spent this amount on resource sharing, the projected savings used to determine the bid price are assumed to be realized. Beyond this point “workload credit” should be negotiated by the MTF and contractor for each subsequent RSA.

(1) Workload Reporting. In order for resource sharing to be cost-effective for both parties it is imperative that the contractor and MTF personnel have a common basis for determining the full impact of resource sharing on MTF workload.

Workload refers to inpatient admissions or outpatient visits as recorded by the MTF. Specific guidelines to workload reporting can be found in Appendix A. The key concept behind workload reporting is determining the number of admissions and outpatient visits, reported by the MTF under the Medical Expense and Reporting System (MEPRS), which would not exist without resource sharing.

For example, if the RSA is for a Podiatrist, workload will be reported as an outpatient visit. If the RSA were for a support service such as a lab technician then the workload may be some percentage of the total lab tests performed, again specific guidelines are in Appendix A.

The second step in the resource sharing process concerning workload is determining the amount of “workload credit” that is going to be given to the contractor for the resource sharing agreement. Once the workload counting method is established, the MTF and the contractor must agree on the amount of “workload credit” that the contractor will receive. The workload credit offsets the actual workload that will be done in the MTF. This ensures that there is not a dis-incentive for the contractor to perform RS. If a workload credit were not given to the contractor, then bid price adjustment would include the workload in the MTF’s utilization as an increase. Denying the contractor the workload credit causes a decrease in the “O” factor resulting in a decreased payment to the contractor. The contractor would then incur two costs associated with doing RS: first, the cost of the RSA itself, and secondly, the decreased payment associated with the decreased “O” factor in the BPA. Therefore, the workload credit was established to provide incentive to the contractor to perform RSAs by offsetting the effect of RSAs on the “O” factor.

As mentioned in the previous section it is appropriate to give the contractor full workload credit (100%) up to the point where the contractor has spent the entire amount stated in the bid for Category 8, resource sharing expenditures. While this is the appropriate credit to give in these circumstances, the workload credit can be negotiated at any time if the MTF does not agree that the RSA is cost-effective to the government if the contractor receives full "workload credit".

(2) Resource Sharing Trend Factor. As one of eight separate trend factors developed by the contractor the resource sharing trend factor is based on a savings to cost ratio estimated by the contractor for the amount of money to be spent on resource sharing. Through the use of this trend factor (less than 1.00) the contractor's original bid price is reduced by the net savings expected from using resource sharing.

For example, if the contractor estimates that for each dollar spent on resource sharing under the contract, CHAMPUS costs will be reduced by \$2.10, this would be reflected in a savings to cost ratio of 2.1. If the contractor plans to spend \$10 million on Category 8 costs for resource sharing then the expected gross CHAMPUS savings would be \$21 million. As a result the contractor's bid price would be reduced by \$11 million, the net savings, that is the gross amount saved, \$21 million, minus the amount spent on resource sharing, \$10 million.

However, the resource sharing trend factor is developed based on the savings-to-cost ratio for resource sharing expenditures. In the above example, if the estimated CHAMPUS costs without resource sharing were expected to be \$55 million, with gross savings of \$21 million and resource sharing costs of \$10 million, then the contractor

would have to bid a resource sharing trend factor of  $[(\$55\text{m} - \$21\text{m})/\$55\text{m} = .62]$  .62 in order to produce a gross savings of \$21 million. The net savings of \$11 million (\$21 m - \$10 m) is reflected in the reduced bid price prior to the savings being realized.

For a better conceptual idea of how the resource sharing trend factor reduces the bid price up front, an aggregate trend factor was used in this example. In the contract there are 210 individual resource sharing trend factors for all seven health care cost categories by ADD and NADD for the prime, extra, and standard programs for each option period. It is also important to note that in the actual bid price formula the resource sharing trend factor is one of eight trend factors whose total product is used for each plan for a particular cost category for each option period (see Table 2). For example, in Table 2, for Extra the total index of .988 is the product of the eight trend factors (i.e.,  $1.04 \times 1.01 \times .98 \times .99$ , ...etc.).

<b>Trend Factors</b>	<b>Prime</b>	<b>Extra</b>	<b>Standard</b>
Inflation	1.04	1.04	1.04
Cost Sharing	1.03	1.01	1.00
Provider Discounts	.98	.98	1.00
COB/TPL	.99	.99	.99
Utilization Rates	1.05	1.02	1.02
Utilization Mgt.	.94	.97	.99
<b>Resource Sharing</b>	.96	.98	.98
Intensity & Other	1.00	1.00	1.02
<b>TOTAL INDEX</b>	.985	.988	1.039

Table 2. Trend Factors for One Cost Category in a Specific Option Period

As mentioned above the "O" factor and resource sharing trend factor act as multipliers of the projected health care costs. If these multipliers are less than one they cause the bid price to go down, if they are greater than one they cause the bid price to go up. The "O" factor is used to account for changes in MTF utilization for each option period as a result of changes in MTF utilization per CHAMPUS eligible beneficiary. These changes are measured against the final DCP projections and the "O" factor is an aggregate measure of MTF utilization for the entire region, rather than for an individual MTF.

## **2. Risk Sharing Feature**

The risk sharing requirement provides a methodology in which the government and contractor may share in both the cost underruns and overruns. Cost overruns occur when the Actual Health Care Services Cost (AHCSC) exceeds the Adjusted Proposed Health Care Services Price (APHCSP), which includes profit on health care services. In turn cost underruns occur when the AHCSC are less than the Adjusted Proposed Health Care Cost (APHCSC), which does not include the contractor's profit. The determination of gains or losses and the risk sharing process occurs at the time of bid price adjustment. A preliminary risk sharing adjustment to the contract price for an option period is calculated at the seventh month following the end of that option period and a final risk sharing adjustment is made at the nineteenth month following the end of that option period.

### ***a. Loss Sharing***

Before the government begins to share in any of the cost overruns, the contractor must first lose all health care services profit plus one percent of the APHCSP. Therefore, if the AHCSC is between 100% of the APHCSC and 101% of the APHCSP then

governments share of the loss is zero. If the AHCSC is greater than 101% of the APHCSP the government's share is 80% up to the Point of Total Government Responsibility (POTGR). The POTGR is the point at which the contractor has absorbed losses equaling the cumulative profit on health care realized for all option periods completed, including any gains realized through gain sharing, plus an additional amount of contractor equity. As a part of the contract, the government requires the contractor to place a specific amount of corporate equity at risk (i.e., \$10 million per option period). This amount must meet or exceed government requirements. At the POTGR the government absorbs 100% of all remaining losses.

The following is a modified version of an example of the loss sharing scenario taken from Captain Montgomery's paper on Resource Sharing Opportunities dated December 1994. Suppose in a given option period, the APHCSC is \$400,000,000 and the fixed health care profit is \$20,000,000. This would make the APHCSP equal \$420,000,000. Now, assume the actual health care cost (AHCSC) experienced by the contractor in the option period is \$450,000,000, that the equity limit for the option period is \$10,000,000, and that there are no prior profits or gains to be considered. The cost overruns or loss for the option period is \$50,000,000 (\$450 m - \$ 400 m).

The government's share in the losses would be as follows:

$$101\% \text{ of the APHCSP} = 101\% \times \$420,000,000 = \$424,200,000$$

AHCSC were \$450,000,000, so the government's share of the loss is

$$(\$450,000,000 - \$424,200,000) \times 80\% = \mathbf{\$20,640}$$



The contractor's loss would be as follows:

Profit plus 1% of bid price

$(\$20,000,000 + (.01 \times \$420,000,000) = \$24,200,000$ , plus

20% of losses not covered by the government

$(.20 \times (\$450,000,000 - \$424,200,000) = \$5,160,000$  for

a total loss of **\$29,360,000**

In this example the amount of equity lost by the contractor is 1% of the APHCSP ( $.01 \times \$420,000,000 = \$4,200,000$ ) plus the 20% loss share of \$5,160,000. This total of \$9,360,000 falls short of the bid equity of \$10,000,000 for the option period, therefore the POTGR does not come into effect and the government does not pay 100%.


***b. Gain Sharing***

Gain sharing adjustments occur when the AHCSC is less than the APHCSC, a cost underrun. The amount shared between the government and contractor is dependent on the size of the gain relative to the APHCSC. This is known as the "gain sharing corridor". If the AHCSC is between 100% and 80% of the APHCSC then the government shares in 80% of the gain and the contractor 20%. If the AHCSC is less than 80% of APHCSC then the gain sharing consists of two calculations. First, the government receives 80% of 20% x APHCSC. Then, the government receives 90% of the remaining gain. The contractor receives 20% of 20% x APHCSC and 10% of the remaining gain.

The following is a modified version of an example of the gain sharing scenario taken from Captain Montgomery's paper on Resource Sharing Opportunities dated December 1994. Suppose that, in a particular option period, the APHCSC is \$400,000,000, and the

AHCSC is only \$300,000,000. Since the AHCSC are 75% of the APHCSC ( $\$300,000,000/\$400,000,000 = .75$ ), this would place the AHCSC in the less than 80% category triggering two gain share computations. The total gain amount to be shared is \$100,000,000, the first 20% of the APHCSC or \$80,000 falls into the government's 80% gain sharing category and the remaining 5% of the APHCSC or \$20,000 falls into the 90% gain sharing category. Thus the government would be allocated (80% of \$80,000,000) \$64,000,000 and (90% of \$20,000,000) \$18,000,000, for a total gain of \$82,000,000. The contractor would be allowed to keep the remainder of the savings, which in this case would be \$18,000,000.

Completing the gain sharing through a variance analysis, as shown below, provides a more illustrative example of the process.

	<u>BPA Proposed Profit</u>	<u>Actual Profit</u>
APHCSP	\$420,000,000	\$420,000,000
APHCSC	<u>\$400,000,000</u>	<u>\$300,000,000</u>
Profit	<u>\$20,000,000</u>	<u>\$120,000,000</u>
		
	<b>Gain Variance</b>	
	\$100,000,000 Favorable	
	To be split between the government and contractor	
	<u>GOVERNMENT</u>	<u>CONTRACTOR</u>
80%[(400M-.80(400M))]	\$64,000,000	
80%(80M) = \$64M		
90%[(400M-.95(400M))]	\$18,000,000	
90%(20M) = \$18M		
	<hr/>	<hr/>
TOTAL	\$82,000,000	\$18,000,000

*c. Risk Sharing and RSAs*

Each RSA has the potential for contributing to either increasing the gains or lowering the losses in the final adjusted contract bid price. RSAs will be cost-effective in either case. RSAs should not be implemented if the FAW does not indicate they will be cost-effective. When evaluating RSAs through the Financial Analysis Worksheet specific estimates will be generated which will reflect the anticipated gains or losses associated with a particular RSA. While estimates are completed for each individual RSA concerning potential gains or losses, the actual gains or losses are calculated on a cumulative basis for an entire Health Services Region. So while one RSA at a particular MTF may be contributing toward a potential gain the region could still incur a loss in the final BPA. The gain/loss sharing provisions using RSAs are the same as those described above.

**C. RESOURCE SHARING AGREEMENT PROCESS**

**1. Identification and Evaluation of Potential RSAs**

The identification and evaluation of RSAs involves three major participants: the MTF, the Contractor, and the Lead Agent. Through their combined efforts Resource Sharing opportunities can be identified that will recapture CHAMPUS workload and optimize the use of MTF resources. Before designating a potential Resource Sharing (RS) application other alternatives should be considered. This is a basic "make or buy" evaluation. This concept is also known as "sourcing" decisions in the business world. For example, rather than own and maintain its computer systems, Kodak outsourced its entire computer operation to IBM.

If the decision is to “make”, the MHSS must arrange for additional military or civil service manning to perform the work. If it is to “buy”, additional services must be purchased through contracting, resource support, or resource sharing. In today’s environment of declining DOD budgets and manpower, establishing new military and civil service billets is very unlikely. If the decision is to buy the use of personal service contracts or resource support will involve using existing MTF operating funds, which are already very limited. As a result, resource sharing provides an attractive alternative for “buy” decisions.

In general, if the MTF has operating funds available, one of the other methods should be explored before utilizing RS. All MTFs face resource constraints such as Operation and Maintenance funding, personnel ceilings, long procurement lead times, and temporary deployments. As a result it is difficult for the MTF to achieve the “right mix” of resources (OASD(HA), Undated). Therefore, most MTFs have some “available” capacity such as clinic space, unstaffed beds, idle Operating Room time, or under-utilized personnel skills. RS enables MTFs to optimize their “available” capacity and recapture CHAMPUS care at a lower overall cost to the government (OASD(HA), undated). Once RS is identified as the best course of action, the cost effectiveness of the agreement must then be evaluated through the Financial Analysis Worksheet, a personal computer based spreadsheet developed by Kennell and Associates for OASD(HA).

*a. Contractor’s Role*

The contractor has built in incentives to perform Resource Sharing since the bid price was decreased to reflect assumed savings through using RSAs. If these front loaded savings are not realized, serious losses might be incurred. As a publicly traded corporation

the contractor is in business to earn a satisfactory rate of return for shareholders. Hence the contractor is under serious pressure to increase profits.

In developing estimated savings from using RSAs, the contractor identified potential areas in their bid proposal where RSAs may be beneficial. In addition, the contractor is required to submit an annual Resource Sharing plan that is developed in conjunction with the MTFs and Lead Agent. The plan identifies advantageous RS opportunities. The contractor must also provide a detailed cost analysis for each RS proposal that includes the actual cost of providing the personnel, equipment and/or supplies, the anticipated increase in services provided within the MTF, the effect of the agreement on the bid price adjustment, the anticipated support required from the MTF and the net savings to the government and the contractor. The contractor is provided with a copy of the government's Financial Analysis Worksheet (FAW) to assist with this cost analysis. The contractor may also use other forms of analysis to evaluate potential RSAs but the officially recognized format is the FAW.

***b. MTF's and Lead Agent's Roles***

The MTF may not have direct incentives to use RSAs as those of the contractor, because the savings associated with using RSAs currently goes to the government as a whole and the individual MTF probably will not receive any of the savings. However, the MTF is generally expected to fund the marginal expenses associated with the RSA out of its current operating budget. Since the government has already benefited from the savings associated through the reduced bid price, there is an implied contract between the government and the contractor to utilize RSAs when they are cost-effective. In addition, while RSAs may

not bring direct dollar savings, RSAs may assist the MTF commander's objective of maximizing the use of the MTF's current personnel and facilities resources.

The MTF and Lead Agent should team with the contractor in developing the contractor's RS plan. The MTF and Lead Agent should also monitor CHAMPUS expenditures and referral patterns for high cost and/or high volume procedures that may be candidates for RS. The MTFs are required to perform an annual environmental assessment for the Lead Agent to assist in the development of a regional business plan. The information collected during this assessment may be used in identifying potential areas where RSAs may be used. The MTF is required to use the FAW in evaluating potential RSAs. This provides the MTF and Lead Agent with a benchmark for comparison with the contractor's workload and cost analysis. All RSAs must be approved by the MTF commander and Lead Agent.

(1) Submission of RSA Proposal. Once an opportunity for a potential RSA is identified the MTF submits a proposal in a format designated by the contractor. The information the contractor needs to perform their analysis includes:

- the number and type of personnel required
- anticipated workload by active duty dependents (ADD) and non-active duty dependents (NADD) beneficiary categories
- the marginal costs (i.e., pharmacy, supply) associated with each visit/admission

This information is forwarded to the contractor where the proposal will undergo analysis for cost effectiveness. The contractor is free to gather information from any sources deemed useful for the analysis. The MTFs should also be doing their own analysis using the FAW.

## **2. Evaluating RSA for Cost Effectiveness**

### ***a. Contractor's Cost Benefit Analysis***

Once the contractor receives a RS request a two step analysis is completed. The first step is to determine the overall appropriateness of the proposal. Does the number of personnel requested match the estimated workload? What is the probability of finding this number and type of providers in the given area? The contractor's analyst will rely on experience in the civilian market and upon prior government experience in answering these questions. The analyst will prepare a cost/benefit analysis comparing estimated costs avoided (in standard, extra, and prime categories by ADD and NADD) to the proposed costs of RS, including marginal costs. This process relies upon government provided computer tapes of data to determine historical CHAMPUS costs over a given period of time and estimated ancillary services generated per visit.(Smith, 1995)

As required by the government the contractor will then use the FAW to determine the agreement's impact on three areas: "hidden dollars" - "O" factor in bid price adjustment; "real dollars"- what is actually paid to providers versus historical CHAMPUS expenditures; "really real dollars" - marginal costs that impact on the MTF's direct budget (Smith, 1995). Details on the content and completion of the FAW are presented in the next section.

### ***b. Completing the Financial Analysis Worksheet***

The OASD(HA)'s contractor, Kennell and Associates, developed a tool to assist Lead Agents, MTFs, and contractors in evaluating proposed RSAs for cost-effectiveness. The section contains excerpts and summaries of the User's Guide for Resource

Sharing Financial Analysis Worksheets written by Kennell and Associates dated October 6, 1995 and the DOD Health Services Region 3 Resource Sharing Manual (undated).

The worksheet is designed to answer two questions for each proposed RSA:

- Is the proposed agreement projected to be cost-effective?
- Is the proposed contractor workload credit appropriate?

An agreement is determined to be cost-effective if the sum of the MTF marginal expenses and the contractor's expenses for the proposed agreement is less than the Government's share of the projected CHAMPUS savings. This is based on the assumption that the government will be gain sharing with the contractor in the BPA.

The second question concerns the appropriateness of workload credit. First, the contractor credit cannot exceed the credit counted under the Guidelines for Resource Sharing Workload Reporting outlined in Appendix A. Second, a profit rate limit may or may not apply dependent on whether the RSAs' savings are already reflected in the initial bid price. For agreements whose savings are included in the bid price, the profit rate on RSAs may exceed the overall contract's health care profit rate (i.e., 5%). For agreements whose savings exceed those assumed in the bid price, the profit rate may not exceed the overall health care profit rate. It is the responsibility of the Lead Agent to monitor contractor expenditures on RSAs within their region and notify the MTFs when overall contractor RS expenditures have exceeded those proposed in the up front bid price. The contractor's projected gains for future agreements once the up-front bid price expenditures are exceeded are subject to profit rate limitations. The "case" page of the FAW makes the determination



of whether the proposed RS expenditures are already included in the contractor's aggregate Best and Final Offer (BAFO) spending assumption. (See Appendix B)

To summarize and recap information presented in earlier chapters and present it in context with the worksheet, internal RS savings can accrue to the government in three ways:

- For those resource sharing investments assumed as part of the contractor's proposal, the contractor's bid price includes a cost-per-eligible (resource sharing) trend factor for resource sharing savings. This creates a lower up-front bid price. These savings are calculated in Section I of the worksheet in Appendix B.
- If partial workload credit is negotiated, the government will realize savings in the Bid Price Adjustment for MTF utilization (the "O" factor). This can result in a more favorable bid price adjustment for the government. These savings are calculated in Section II of the worksheet in Appendix B.
- In accordance with the risk sharing provisions of the contract the government will also realize 80 or 90 percent of any gains associated with RS as a result of a favorable bid price adjustment for the entire region. The actual percentage depends on the amount of the gain. These savings are calculated in Section IV of the worksheet in Appendix B.

Under external RS the government has not received up front savings from the contractor's BAFO proposal, since the BAFO does not include external RS. Instead RS savings accrue in two ways:

- Partial contractor workload credit which results in "O" factor savings in the BPA
- Same risk sharing provisions outlined under internal RS

In accordance with the contract, MTF commanders or their designated representatives are required to complete the FAW in negotiating each proposed RSA, in addition to any other analyses prepared by the contractor or the MTF. The worksheet itself can be broken down into three parts, the first being a series of inputs required to calculate the cost-effectiveness of the agreement, the second being the BAFO data page, and the third being the five section output from using the inputs, the BAFO data, and the case page. (See Appendix B)

(1) Inputs to Financial Analysis Worksheet.

- Option Period: The option period covered by the proposed agreement. A new worksheet must be completed each year since the cost-effectiveness of an agreement may change.
- Contractor Expenditures: The expected contractor expenditures for Category 8, resource sharing, costs for CHAMPUS and non-CHAMPUS eligibles for this specific RSA; the expected Category 8 costs for non-CHAMPUS eligibles only; and the expected costs for CHAMPUS eligible only. The expected costs can be estimated by using the prior year cost of a partnership agreement (if there is no anticipated change in workload), the number of workload units expected to be produced multiplied by the expected provider fee for service, or by the total resource sharing capitated salary of all expected providers and professional staff.
- MTF Marginal Expenditures: The projected MTF marginal expenditures for both CHAMPUS and non-CHAMPUS eligibles. The MTF marginal expenditures for CHAMPUS eligibles only. Currently the best source for determining the marginal expenditures associated with a particular agreement is the Medical Expense and Performance Reporting System. MEPRS allows MTFs to step down the ancillary and supply costs associated with specific cost centers.
- Workload Credit: The contractor RS workload credit assumed in the analysis. It is appropriate to give the contractor 100% workload credit up to the point where the contractor exceeds the proposed RS expenditures in the initial bid price. However, if an agreement does not come out favorable using the contractor 100% credit, the credit may be negotiated to a lower percentage.

- MTF Admissions/Visits Enabled by Resource Sharing: The number of MTF admissions and outpatient visits enabled by the RSA by ADD and NADD for CHAMPUS and non-CHAMPUS eligibles. This count may include admissions and visits indirectly associated with the RSA (i.e., RSA for anesthesiologist or nursing staff); The number of MTF admissions and outpatient visits broken down by CHAMPUS and non-CHAMPUS eligibles only.
- Expected Risk Sharing Responsibility: It is assumed that the contractor will efficiently and effectively carry out the agreement and lower overall CHAMPUS expenditures. Therefore, Kennell and Associates recommends use of the 80% gain sharing category. As a result the government will share in 80% of any gains associated with the agreement and the contractor will keep 20%.
- Estimated Volume Trade-Off Factor: The volume trade-off factor specific to this RSA for admissions or outpatient visits. It is anticipated to be lower than the VTF for MTF care overall provided in the RFP. This factor is used to estimate CHAMPUS avoidance savings. This is a key factor when evaluating a potential RSA so the assumptions made concerning the VTF should be monitored closely if the agreement is implemented. There is no standard method for estimating the VTF prior to establishing the RSA but the MTF can monitor the change in CHAMPUS costs once the agreement is in place. If the VTF is higher than expected the agreement may not be cost-effective (i.e., every 3 MTF visits corresponds to a reduction in 1 CHAMPUS visit instead of every 2 MTF visits corresponding to a reduction in 1 CHAMPUS visit).
- Estimated CHAMPUS Cost Avoidance: These costs are calculated one of two ways: 1) the total government CHAMPUS costs and units for the workload affected are used to calculate the average government cost per unit for admissions or outpatient visits avoided in CHAMPUS by ADD and NADD for the care covered under this agreement; 2) average government CHAMPUS unit costs are provided from some other data source such as the Retrospective Case-Mix Analysis System (RCMAS).
- Sum of Projected Resource Sharing Expenditures: This is the total amount spent on RSAs by the contractor for the entire region. This value must be provided by the Lead Agent and is used to determine whether the proposed RSA expenditures and the resulting savings are already included in the bid price. The Lead Agent monitors these expenditures and informs the MTF when the contractor has exceeded the projected expenditures in the bid price so that the profit limitations are taken into consideration when sharing any projected gains of future RSAs.

These are all of the inputs required for the FAW. The MTF and contractor may use any estimates or assumptions they feel appropriate to complete the individual worksheets. However, as part of the negotiation of the RSA a combined finalized worksheet must be completed. The MTF and contractor must agree on each estimate and assumption entered under the input section for the final worksheet. The remaining FAW sections do not require the MTF or contractor to enter any data or assumptions.

(2) Best and Final Offer (BAFO) Data Page. This page is provided by OASD(HA) with the worksheet template for each of the MCSCs. This page reflects the original data in the contractor's BAFO. OASD(HA) will provide a revised version of this page based on the results of the preliminary and final actual DCP data. The BAFO data page includes the following contractor's data and assumptions:

- The assumed savings-to-cost ratio used to develop the resource sharing trend factor.
- The number of CHAMPUS eligibles in the DCP and each option period by ADD and NADD.
- The CHAMPUS cost-per-eligible for each option period for categories 1 to 3 inpatient care by ADD and NADD.
- The CHAMPUS cost-per-eligible during for each option period for categories 4-7 outpatient care by ADD and NADD.
- The percentage of inpatient costs related to admissions requiring NASs during the DCP by ADD and NADD.
- The number of inpatient NASs without the RSA in the DCP and the option periods by ADD and NADD.
- The number of CHAMPUS outpatient visits in the DCP by ADD and NADD.

- The volume trade-off factor assumed in the contract for outpatient visits (this is used to calculate the "O" factor adjustment).
- The number of MTF outpatient visits (non-OB/GYN, there is no such thing as an OB/GYN outpatient visit in the civilian sector so these figures are subtracted out, also does not include partnership visits as they are counted as CHAMPUS visits) without the RSA in the option periods by ADD and NADD.
- The contractor's proposed profit rate for overall health care costs for each option period.

### (3) Five Section Output of Financial Analysis Worksheet.

- Section I This section estimates the net resource sharing savings under this agreement which would already be reflected in the contractor's proposed bid price, based on the savings:cost ratio used to develop the resource sharing trend factor in the contractor's BAFO. This analysis ensures that the determination of the contractor's workload credit for resource sharing reflects those savings to the government which the contractor already included in its bid price for the contract. If the case page indicates that the sum of the expenditures for the RSAs already approved exceeds the aggregate Category 8 RS expenditures in the contractor's BAFO, then none of the savings from the proposed RSA would be reflected in the contractor's BAFO.
- Section II This section estimates the effect of the RSA, including the contractor's workload credit, on the MTF utilization adjustment in the Bid Price Adjustment Formula (i.e., the "O" factor adjustment). This section calculates the "O" factor with and without the proposed RSA, and calculates the government savings associated with any partial contractor workload credit. Partial workload credit for the contractor would result in a lower "O" factor due to increased MTF utilization and therefore a lower adjusted bid price.
- Section III This section estimates the actual savings (i.e., cost avoidance) in CHAMPUS category 1-7 health care costs as a result of the RSA. These savings are based on the projected number of CHAMPUS admissions and/or outpatient visits avoided as a result of the proposed RSA and the cost of each unit avoided in CHAMPUS.
- Section IV This section estimates the residual gain in CHAMPUS (i.e., the difference between the APHCSC and the AHCSC) under the proposed RSA. This section also estimates the government and contractor portions of these gains, since

the gains would be subject to risk sharing between the government and the contractor. These gains are for one particular agreement and in order for any of the gains to be realized the AHCSC must be lower than the APHCSC for the entire region during the option period.

- Section V This section poses the two necessary questions and provides the answers to those questions to complete the analysis. First, is the contractor credit for resource sharing workload assumed in the analysis appropriate? Second, does the analysis indicate that the proposed RSA would be cost-effective for the government from the MHSS perspective? The answers to these questions are automatically determined and presented in the worksheet.

It is recommended that the answer to both questions be “yes” before proceeding with the agreement. If the answer to the question concerning cost-effectiveness to the government is “no”, the contractor and MTF may reevaluate the assumptions for the volume trade-off factors, responsibility for marginal costs, CHAMPUS allowable discount, or varying the risk sharing provisions within the worksheet. If the answer to the question regarding workload credit is “no”, the MTF and contractor may negotiate the workload credit. In most cases this will only occur after the contractor has exceeded the BAFO’s Category 8 RS expenditures.

If it is not possible to negotiate the estimates, assumptions, or workload credit in order to get a “yes” response to both questions then the proposed RSA should not be approved unless extenuating circumstances exist that compel the agreement to be approved. In situations where a positive outcome cannot be reached through negotiation it may be more viable to use another alternative (i.e., resource support) or reject the agreement and let the service be absorbed by standard CHAMPUS.

### **3. Monitoring Resource Sharing Agreements**

Since the RSA was determined to be cost-effective based on estimates and assumptions it very important that RSAs are continually monitored to ensure the agreements are actually cost-effective. However, there is currently no formal policy or standardized method for monitoring RSAs. MTFs should frequently examine the workload the RSA has generated and compare it with expectations to evaluate how the RSA is performing. However, it is difficult for the MTFs to measure the RSAs effect on CHAMPUS workload due to the time lag associated with CHAMPUS claims data.

### **4. Overview and Summary**

The responsibility for initiating and recommending RSAs currently rests on both the MTF and the Contractor. The Lead Agent provides a regional coordination of RSAs for monitoring the dollar amounts spent on RSAs by the contractor for all MTFs within their respective Region. The monitoring of expenditures by the Lead Agent is important when determining the amount of workload that will be credited to the contractor under the RSA because of its impact on the bid price adjustments. The Lead Agent also provides assistance in evaluating RSAs for cost-effectiveness.

Since the Contractor's bid price already reflects anticipated savings through the use of RSAs and the government has already realized savings through this reduced price, it is in the best interest of both parties to pursue RSAs. However, before an RSA can be established it must be proven cost-effective for both the government and the contractor. MTFs should be looking for "win-win" agreements in which both the contractor and the government share in the savings. Sometimes contractors are willing to enter into "win-lose" agreements if the

resource sharing counts toward their planned amount of savings to the government.

MTFs and contractors are provided a tool, the FAW, for evaluating potential agreements. This worksheet is the primary tool used to evaluate potential RSAs for their cost-effectiveness to both the government and the contractor. In the next chapter we will discuss specific case studies in which Resource Sharing has been used to avoid CHAMPUS costs and optimize MTF resources.



## **IV. APPLICATION OF RESOURCE SHARING AGREEMENTS**

### **A. GENERAL**

This chapter provides case studies of RSAs and subsequent concerns of the RS program. As mentioned previously there are three categories of RS: 1) CHAMPUS cost avoidance, 2) recaptured CHAMPUS workload, and 3) CHAMPUS partnership conversions. One case study is based on an actual internal cost avoidance RSA that was developed for a major medical center for colposcopy services. The identity of the MTF is not important. The actual numbers used in evaluating the RSA are disguised because some of the data contained in the actual agreement are proprietary.

In addition, two other case studies will be utilized to show an internal recaptured CHAMPUS workload RSA for Podiatry services and an internal Partnership conversion RSA for Pediatrics. While there are some differences in the overall evaluation of each type of agreement the process of completing and utilizing the FAW is the same for all three types of RSAs.

Since the majority of RSAs involve internal agreements as opposed to external agreements, the focus here is on internal RSAs. The lack of a formalized Financial Worksheet available to all Health Service Regions to evaluate external agreements is another reason for not addressing them in this thesis.

## **B. COST AVOIDANCE RESOURCE SHARING AGREEMENT**

### **1. General**

The cost avoidance type of RSAs result from changes in MTF utilization due to the loss of an MTF provider that existed in the DCP or increases in workload that did not exist in the DCP. For example, if a certain service was provided by an MTF provider during the DCP then it was counted as MTF workload. If subsequent to the DCP the MTF loses the provider then the decrease in MTF workload associated with the lost provider will result in decreased MTF utilization in comparison with the DCP. The decrease in MTF utilization results in a higher "O" factor at bid price adjustment which in turns increases the contractor's cost that the government pays for in higher prices.

Another example of a situation where the contractor's cost may increase is when the MTF workload for a particular service increases beyond the point where the MTF reaches its capacity. As a result, the extra workload must be seen by the contractor which increases the CHAMPUS cost.

In both examples, RS is a potential tool to avoid the additional CHAMPUS costs associated with the above changes. It is assumed that through using RSAs the contractor will be able to provide the services at a lower cost in the MTF than under their civilian network for TRICARE. This is verified through the Financial Analysis Worksheet.

The MTF must be aware that there will be additional costs associated with this type of RSA at bid price adjustment, because this workload was either counted as MTF workload during the DCP or did not exist during the DCP. The amount of increase is dependent on the amount of "workload credit" given to the contractor for the particular RSA. On the surface

this does not sound like much of a savings since the contract price is still going to be higher at bid price adjustment regardless of whether we do the RSA or not. However, it is important to note that if this workload was not being seen in the MTF under the RSA agreement then the workload would be seen under TRICARE through the civilian network at a higher cost. This type of an agreement is one in which we are minimizing the cost associated with losing a provider or incurring additional workload by implementing an RSA.

One of the problems associated with evaluating this type of agreement involves the determination of the VTF. As mentioned above it is assumed that the health care provided through the RSA is less costly than under the civilian network established for TRICARE. In most cases, however, the amount of workload seen under TRICARE for the same service will be less than the workload seen in the MTF. This is a result of such factors as free care in the MTF and co-pays associated with TRICARE. There is currently no standardized method for determining VTFs.

## **2. Sample Case Study of a Cost Avoidance RSA**

The American College of Obstetrics and Gynecology published a new standard for colposcopy examinations in the Spring of 1995 which increased the need for this service. In the past colposcopy examinations were required subsequent to two abnormal pap smear tests being returned on the patient. Under the new standard this service is now required after one abnormal pap smear. At the time this change in standards was issued all colposcopy services were provided in house at the MTF. The MTF now had a requirement for additional workload that could not be done entirely in-house with current resources. The workload associated with these new requirements was not in the DCP data and therefore was going to

be subject to bid price adjustment.

The MTF initially discovered the additional workload requirements through notification from the Head of the Department providing the service of a change in the standard of care. In addition there was an increase in the number of disengagements for colposcopys. A disengagement is a form issued to eligible beneficiaries to seek care under CHAMPUS when their care cannot be provided by the MTF.

The MTF then had to determine the best way to meet this additional workload requirement. As mentioned earlier, in most cases the MTF should first seek other means to meet the additional workload requirements before using RSAs. In this case the MTF increased its own utilization through training additional providers within the MTF and satellite clinics to perform colposcopys. While this increased the MTF's utilization in providing colposcopys it still did not cover all of the new workload. Thus, the MTF began the process described in the following sections for preparing a potential RSA.

*a. Workload*

This RSA process began by determining the number of disengagements issued for colposcopy service after the MTF had reached its full capacity. At this point the MTF reviewed the type of patients disengaged to ensure the majority were CHAMPUS eligible. In order for the RSA to produce the necessary cost savings/avoidance, the majority of the patients should be CHAMPUS eligible. The MTF then began working with the department to develop a statement of work that included the scope of work, the hours of service, number of providers and support personnel needed, and a ceiling for the expected number of visits per month. The MTF estimated the additional demand based on the number of disengagements

completed since the change in the standard of care. Placing a ceiling on the number of RS visits prevents shifting of workload previously done by the MTF to the contractor.

As stated above, in this type of agreement there will be an increase in the contractor's cost at bid price adjustment due to the new workload performed under the RSA that was not included in the DCP. It is important that the amount of workload that was being done by the MTF during the DCP continue to be performed in the MTF. Maintaining the MTF's baseline established in the DCP avoids having the contractor's cost further increased by any additional workload due to a decrease in MTF utilization. If the MTF's workload does decrease from the baseline established in the DCP, there will be additional costs at bid price adjustment. Conversely, if the present MTF workload exceeds the DCP workload, then MTF utilization has increased and there should be a decrease in contractor's cost at bid price adjustment.

For example, if the current workload for this procedure is 150 visits and the MTF was doing 100 visits during the DCP then MTF providers must account for at least 100 visits. This avoids the effect of two cost increases at bid price adjustment, one increase for the additional workload to be performed under the RSA and another increase due to a decrease in MTF utilization. If the MTF saw 110 visits then the remaining 40 visits were done under the RSA and at bid price adjustment two of events would take place: 1) the contractor's cost would be increased, assuming 100% workload credit, by the RSA workload, in this case 40 visits, and 2) the government's cost would be decreased due to the increase in MTF utilization relative to the DCP (i.e., going from 100 visits to 110 visits). If the MTF saw 90 visits then the remaining 60 visits were done under the RSA and at bid price

adjustment the contractor's cost would be increased, assuming 100% workload credit, by the RSA workload, in this case 60 visits. If the adjustment for 50 visits was expected under the RSA, however, the government's cost would increase further as a result of the decrease in MTF utilization relative to the DCP (i.e., going from 100 visits to 90 visits).

***b. Marginal Costs***

The next step involved determining the marginal costs associated with the RSA. While there is no standardized method for determining the marginal costs, the MEPRS cost data is commonly used. The MTF estimates such marginal costs as ancillary services and supply expenses for the RSA. These costs were determined to be approximately \$8,540 per year. If the agreement involved a lost provider rather than new workload, the MTF marginal costs (i.e., pharmacy, lab, supplies) would not be as big a factor in evaluating the agreement. The reason it would not be a major factor is because the marginal costs were already being incurred as a result of the MTF provider.

***c. Submission of Request***

When all the requirements and marginal costs were identified a request for the RSA was submitted to the contractor, and a copy to the Lead Agent. It contained the following: a short narrative of the proposed scope of work, estimates of the types and amounts of providers and support personnel, qualification requirements for providers needed, and MTF specific cost and workload information associated with the past year's patient workload and ancillary workload.

***d. Establishing Volume Trade-Off Factor***

Another part of the process involved the contractor and MTF agreeing upon

the VTF to be used in the FAW. As discussed previously, the VTF assumes that not all patients disengaged for a particular MTF service will seek that treatment under CHAMPUS. The service provided for this particular agreement was the result of negative pap smears which could have posed serious health concerns if not addressed. Therefore, it was assumed that most of the patients disengaged would seek treatment under CHAMPUS. Therefore, a VTF of 1.2 was used for the cost-effectiveness analysis.

*e. Cost Analysis*

Once this information was received the contractor prepared a cost analysis using the FAW to determine the cost-effectiveness of the agreement, as well as do their own cost benefit analysis to determine their costs and estimated savings (CHAMPUS costs avoided). The MTF's cost analysis did not include the completion of the FAW as part of their submission request. The MTF did provide all necessary cost estimates and assumptions to allow the contractor to complete the FAW. In fact, other MTFs in two HSRs were not using the FAW to conduct their own analysis, but supplied the contractor with the necessary input factors for the contractor to complete the FAW. In all cases the MTF and Lead Agent thoroughly reviewed and verified the contractor's FAW and any other cost analyses before approving the RSA.

There were several reasons stated for the worksheet not being used, among them were: 1) some MTFs did not have the necessary software to use the worksheet, 2) did not know where to get the information needed to complete the worksheet, and 3) did not understand how to use the worksheet.

*f. Bid Price Savings*

The FAW revealed that the proposed Category 8, RS expenditures, for this RSA were already included in the contractor's aggregate spending assumption. As a result the MTF and contractor agreed that the contractor receive 100% workload credit for this RSA. The next section contains a summary of the FAW contained in Appendix C.

*g. Financial Analysis Worksheet Results*

(1) Section I: Assumed Savings Reflected in BAFO. This section determined the amount of Resource Sharing Savings (costs avoided) already reflected in the proposed bid price assumptions. The contractor expected to spend approximately \$97,891 in Category 8, resource sharing expenditures, under this RSA. The assumed savings to cost ratio that was used to develop the resource sharing trend factor in the original bid price was 2.2. As a result the expected savings for this agreement was \$215,360 ( $\$97,891 \times 2.2$ ). Thus, the net savings (cost avoided) already reflected in the bid price was \$117,469, which is the gross savings of \$215,360 minus the cost of the RSA, \$97,891.

(2) Section II: "O" Factor Impact on Bid Price Adjustment. This section estimated the impact of the RSA on MTF utilization (i.e., "O" factor). Since the contractor was given 100% workload credit for this RSA there was no impact on the "O" factor as a result of this agreement. If the agreement had provided only partial workload credit to the contractor, then there would have been a decrease in the "O" factor since the MTF workload would not be adjusted for the contractor's total workload credit.

(3) Section III: Impact on CHAMPUS Claims Costs. This section estimated the actual savings (CHAMPUS cost avoided) as a result of the RSA. The workload



enabled by this RSA was estimated to be 439 ADD and 695 NADD. Using the VTF of 1.2 the number of CHAMPUS visits avoided was determined to be 366 ADD and 579 NADD. The contractor's cost analysis estimated \$322,328 in CHAMPUS costs avoided. These costs avoided did not take into consideration the VTF. Therefore, dividing the total estimated costs avoided (without VTF) by the total number of MTF visits enabled by the RSA, the average government cost per unit for CHAMPUS visits avoided was determined to be \$285 for both ADD and NADD. Then taking the VTF into consideration the estimated CHAMPUS costs avoided were determined to be (366 ADD visits x \$285) \$104,263 plus (579 NADD visits x \$285) \$165,063 for a total of \$269,325.

(4) Section IV: Risk Sharing Impact. This section addressed the residual gain or risk sharing impact of the RSA. In this agreement the government shared in 80% of the risk and the contractor shared in 20% of the risk. As stated above the contractor's Category 8, RS expenditures, were estimated to be \$97,891. In order to calculate the net decrease in actual CHAMPUS costs from the estimated CHAMPUS costs avoided (calculated in Section III) subtract the contractor's RS expenditures,  $\$269,325 - \$97,891 = \underline{\$171,434}$ . The amount of savings (costs avoided) reflected in the up-front bid price (calculated in Section I) are then subtracted to calculate the residual gain to be shared between the government and the contractor,  $\$171,434 - \$117,469 = \underline{\$53,965}$ . The government and contractor then split the \$72,598 using the 80% -20% risk sharing guidelines. The resulting government gain is \$43,172 (80% x \$53,965) and the resulting contractor gain is \$10,793 (20% x \$53,965).

(5) Section V: Results of Analysis. This section provided the final results of the analysis concerning the contractor workload credit and cost-effectiveness from the MHSS perspective. The analysis showed that the contractor's initial contractor RS expenditures, \$97,891, and the resulting savings were already included in the BAFO price. Therefore, the agreement yielded a "yes" answer to the "workload credit" question. The contractor's residual gain was calculated to be \$10,793 which represented a residual profit of 11.03%. The residual profit is calculated by dividing the RS expenditures by the residual gain for the RSA ( $\$10,793/\$97,891$ ). The contractor's proposed profit rate for the overall health care costs from the BAFO was 3.5%. Since the RS expenditures and savings (costs avoided) were determined to be reflected in the BAFO price it is appropriate to give the contractor 100% workload credit for this RSA. If the expenditures and savings were not a part of the BAFO price the contractor's residual profit rate on any gain associated with an RSA should not exceed the proposed 3.5% profit rate for overall health care costs. The analysis for cost-effectiveness took the projected MTF marginal expenditures, \$8,540, and subtracted the costs from the projected government gain to calculate the net government savings (cost avoided) under the RSA. The projected government gain is the up-front bid price savings plus the 80% of the residual savings associated with the RSA,  $(\$117,469 + \$43,172) = \$160,641$ . The net government savings is expected to be  $\$160,641 - \$8,540 = \$152,101$ . Government gains exceed government expenditures therefore the agreement yields a "yes" answer to the cost-effectiveness question.

The Financial Worksheet Analysis revealed the RSA elicited "yes", "yes" responses to both of the questions needed to implement the RSA. Upon completion of all analyses and agreements among all parties concerning the assumptions and scope of work of the RSA, signatures are obtained from the contractor, Lead Agent, and MTF Commander to approve the RSA. The actual RSA used as a basis for this study is scheduled to be implemented in July 1996.

### **C. RECAPTURE OF CHAMPUS WORKLOAD RESOURCE SHARING AGREEMENT**

#### **1. General**

The recapture of CHAMPUS workload type of RSA involves an agreement which brings workload into the MTF that was previously done under CHAMPUS. It is assumed that the contractor, through the use of RS, can provide the care for less cost than under the civilian network associated with TRICARE. This is because the contractor should be able to contract with providers at a discount rate since they will have no overhead or supply costs. The costs and assumptions must be agreed upon by the contractor and MTF just as in the other types of agreements. These costs and assumptions include the contractor's cost of the agreement, the MTF's marginal costs, the CHAMPUS costs saved (avoided), establishment of a VTF, the workload estimate, and a determination of the contractor's "workload credit".

#### **2. Sample Case Study of a Recapture of CHAMPUS Workload RSA**

This sample case study centers around an RSA developed to provide Podiatry services. It was found through a review of referral reports that an MTF was disengaging a high number of podiatry cases. The MTF currently had only one military Podiatrist who was

operating at full capacity.

Efforts were made through a variety of avenues to bring some or all of this workload back into the MTF. The MTF tried to establish another military billet for a Podiatrist but the request was turned down. The MTF considered using a personnel services contract for a Podiatrist. However, the time frame for this process was approximately one year and the MTF did not have the operating funds to implement this type of contract. Another option was the use of resource support but, again the MTF did not have the operating funds to purchase the services through the MCS contractor. The MTF then decided to review further the types of patients that were being disengaged. The assessment indicated that the majority of patients were CHAMPUS eligible. Since most of the workload was CHAMPUS eligibles it became apparent that an attempt to recapture this CHAMPUS workload could be done with an RSA. The MTF then began the process of requesting an RSA.

The MTF began working with the Podiatry Department to develop the requirements needed to recapture the CHAMPUS workload. This included the development of the scope of work, the hours of service, number of providers and support personnel needed, and an estimated number of visits per month. It was important to provide good workload estimates for the same reasons in the cost avoidance RSA. Since this agreement involves a service provided by both MTF and RS providers, the MTF providers must continue to perform the same amount of workload as was counted in the DCP. By maintaining the baseline visits in the DCP the MTF ensures against a negative bid price adjustment for decreased MTF utilization.

In determining the requirements for the agreement the MTF calculated the expected MTF marginal expenditures associated with the potential RSA. This was done using the MEPRS cost data just as in the cost avoidance RSA. The MEPRS data was used to estimate the marginal costs in the area of pharmacy, lab, radiology, anesthesia, surgical suite, and recovery room costs. The total of these costs was expected to be around \$1,500 per year.

When all the requirements and marginal costs were identified a request for the RSA was submitted to the contractor, and a copy to the Lead Agent, that contained a short narrative of the proposed scope of work, estimates of the types and amounts of providers and support personnel, qualification requirements for providers needed, and MTF specific cost and, patient and ancillary workload information.

In this case study the MTF was able to complete the FAW based on their own cost and workload estimates, and assumptions concerning the "workload credit" and VTF.

This scenario assumes that the contractor has already exceeded the amount of Category 8 expenditures stated in the BAFO and the government has realized all of the up-front bid price reduction savings. Therefore, the "workload credit" for all subsequent agreements should be negotiated and the contractor's profit rate should be limited to the BAFO profit rate for overall health care costs. With the above in mind the MTF and contractor compared their individual Financial Analysis Worksheet results and began negotiating the key assumptions and cost data in order to come up with an RSA that was cost-effective to both.

For this agreement the MTF and contractor agreed upon a 45% "workload credit". The negotiated workload credit of 45% was considered cost-effective to both the government

and contractor and also ensured that the contractor's profit on the RSA did not exceed the BAFO profit rate on overall health care costs. The results of the analysis with the contractor spending \$95,000 for the agreement, the MTF marginal expenditures of \$1,500, a 45% "workload credit", estimated visits of 525 ADD and 300 NADD, an 80-20 split for any gains, a 1.5 VTF, and an estimated cost of \$225 per visit elicited the results in the FAW contained in Appendix D and summarized in the next section.

*a. Financial Analysis Worksheet Results*

(1) Section I: Assumed Savings Reflected in BAFO. This section determined the amount of Resource Sharing savings already reflected in the proposed bid price assumptions. The contractor expected to spend \$95,000 on the RSA. The contractor had already exceeded the amount of Category 8 RS expenditures proposed for the option period. Therefore, the CHAMPUS savings already reflected in the bid price were \$0.

(2) Section II: "O" Factor Impact on Bid Price Adjustment. This section calculated the estimated impact of the RSA on MTF utilization (i.e., the "O" factor for outpatient visits) and the decrease in the bid price due to the adjustment of the "O" factor. Since the contractor was given a 45% "workload credit", MTF utilization increased by the remaining 55%. The "O" factor for ADD without the RSA was 1.166723147, the re-calculated "O" factor for ADD with the RSA was 1.165896115. The decrease in the "O" factor was a result of the MTF increasing their utilization by 289 ADD visits ( $55\% \times 525$  visits). The "O" factor for NADD without the RSA was 1.201091634. The re-calculated "O" factor for NADD with the RSA was 1.200947100. The decrease in the "O" factor was a result of the MTF increasing their utilization by 165 NADD visits ( $55\% \times 300$  visits). The

actual decrease in costs is determined by calculating the costs without the RSA and then subtracting out the cost with the RSA. The calculation for the costs without the RSA was done by taking the number of CHAMPUS eligibles in the BAFO data by ADD and NADD and multiplying by the average outpatient cost (category 4-7 costs) per eligible for ADD and NADD and then multiplying the result by the "O" factor for ADD and NADD without the RSA. The cost calculation with the RSA multiplies the number of CHAMPUS eligibles in the BAFO data by ADD and NADD by the average outpatient cost (category 4-7 costs) per eligible for ADD and NADD. The result is then multiplied by the "O" factor for ADD and NADD with the RSA. The sum of the difference between the two for ADD and NADD represents the decrease in government costs as a result of the RSA. For ADD the calculation is  $(68,573 \text{ CHAMPUS eligibles} \times \$221 \text{ average outpatient cost per eligible} \times 1.166723147 \text{ outpatient "O" factor without RSA}) - (68,573 \text{ CHAMPUS eligibles} \times \$221 \text{ average outpatient cost per eligible} \times 1.165896115 \text{ outpatient "O" factor with RSA}) = \$12,519$ . For NADD the calculation is  $(137,914 \text{ CHAMPUS eligibles} \times \$292 \text{ average outpatient cost per eligible} \times 1.201091634 \text{ outpatient "O" factor without RSA}) - (137,914 \text{ CHAMPUS eligibles} \times \$292 \text{ average outpatient cost per eligible} \times 1.200947100 \text{ outpatient "O" factor with RSA}) = \$5,818$ . The total decrease in the bid price due to the "O" factor adjustment for this RSA is  $\$12,519 + \$5,818 = \underline{\$18,337}$ .

(3) Section III: Impact on CHAMPUS Claims Costs. This section estimated the actual savings (CHAMPUS cost avoided) as a result of the RSA. In this agreement the workload enabled by this RSA was estimated to be 525 ADD and 300 NADD, using the VTF of 1.5 the number of CHAMPUS visits avoided was 350 ADD and 200

NADD. Through the contractor's cost analysis the estimated CHAMPUS costs avoided were \$185,625, but these costs avoided do not consider the VTF. So dividing the total estimated costs avoided (without VTF) by the total number of MTF visits enabled by the RSA equals the average government cost per unit for CHAMPUS visits avoided which was determined to be \$225 for both ADD and NADD. Using the VTF the estimated CHAMPUS costs avoided were (350 ADD visits x \$225) \$78,750 plus (200 NADD visits x \$225) \$45,000 for a total of \$123,750.

(4) Section IV: Risk Sharing Impact. This section addressed the residual gain or risk sharing impact of the RSA. In this agreement the government shared in 80% of the risk and the contractor shared in 20% of the risk. As stated above, the contractor's Category 8, RS expenditures, were estimated to be \$95,000. The net decrease in actual CHAMPUS costs equals the estimated CHAMPUS costs avoided (calculated in Section III) minus the contractor's RS expenditures or  $\$123,750 - \$95,000 = \underline{\$28,750}$ . In this case there were no up-front savings reflected in the bid price. However, the decrease in the bid price due to the "O" factor adjustment must be subtracted from the net decrease in actual CHAMPUS costs to calculate the residual gain to be shared between the government and the contractor,  $\$28,750 - \$18,337 = \underline{\$10,413}$ . The government and contractor then split the \$10,413 using the 80% -20% risk sharing guidelines. The resulting government gain is \$8,330 (80% x \$10,413) and the resulting contractor gain is \$2,083 (20% x \$10,413).

(5) Section V: Results of Analysis. This section provided the final results of the analysis concerning the check of contractor workload credit and cost-effectiveness from the MHSS perspective. The analysis showed that the contractor's initial



RS expenditures, \$95,000, were not part of the proposed BAFO expenditures for RS and thus there were no resulting savings included in the BAFO price. Since the RS expenditures were not reflected in the BAFO price it was appropriate to negotiate the "workload credit" in order to make the agreement cost-effective. The contractor was given 45% workload credit for this RSA. The contractor's residual gain was calculated to be \$2,083 which represented a residual profit of 2.19% ( $\$2,083/\$95,000$ ). The contractor's proposed profit rate for the overall health care costs from the BAFO was 3.5%. In accordance with the contract policy the contractor's profit for this RSA did not exceed the profit rate for overall health care costs. Negotiating the "workload credit" at 45% kept the contractor's profit under 3.5% for this agreement thereby eliciting a "yes" answer to the appropriateness of the "workload credit". The analysis for cost-effectiveness took the projected MTF marginal expenditures, \$1,500, and subtracted the costs from the projected government gain to calculate the net government savings (cost avoided) under the RSA. The projected government gain is the up-front bid price savings, which in this RSA was \$0, plus the 80% of the residual savings associated with the RSA, and the savings from the "O" factor adjustment ( $0 + \$8,330 + \$18,337$ ) \$26,667. The net government savings is expected to be  $\$26,667 - 1,500 = \underline{\$25,167}$ . Government gains exceed government expenditures therefore the agreement yields a "yes" answer to the cost-effectiveness question.

In this example we have seen how RS can produce government savings through recapturing CHAMPUS workload and the effects of using RS once the contractor has exceeded the proposed expenditures for RS in the BAFO. The government realizes savings by providing care in the MTF through the contractor at a lower cost than would be

incurred under TRICARE. In this RSA case, to be cost-effective the MTF had to negotiate a VTF and “workload credit” that would lower the contractor’s profit rate under the BAFO proposed profit rate for overall health care costs but at the same time be beneficial to both parties.

#### **D. PARTNERSHIP CONVERSION RESOURCE SHARING AGREEMENT**

##### **1. General**

The Partnership program allowed CHAMPUS eligible beneficiaries to receive inpatient or outpatient treatment from civilian providers in an MTF, or from uniformed services providers of care in civilian facilities. The premise for these programs is that the care provided under the Partnership program is more economical than Standard CHAMPUS. This type of agreement involves the conversion of internal/external partnerships at MTFs into RSAs. Since the MCSC requires the contractor to provide the civilian network for the TRICARE program, all Partnership programs with other third parties are either discontinued or converted into an RSA.

The evaluation of an RSA that involves the conversion of a Partnership is the same as that used for Cost Avoidance and Recapture of CHAMPUS workload RSAs. The main difference and key factor to be aware of in evaluating this type of agreement involves inpatient RSAs. When evaluating an inpatient Partnership for conversion to an RSA the MTF must know if the Partnership existed during the DCP. If the Partnership existed during the DCP, the MTF needs to determine if CHAMPUS admissions for the Partnership were counted in the DCP data reported by OCHAMPUS. If the admissions were not counted, then the “workload credit” for converting the RSA should be negotiated so that the contractor’s

profit rate is approximately equal to zero. The "workload credit" is negotiated because the admissions associated with the Partnership did not exist in the DCP. Therefore, it would not be appropriate to give the contractor full credit. If the admissions/visits were counted in the DCP then it is appropriate to give the contractor 100% workload credit.

Additionally, when evaluating conversions the MTF should have actual past workload counts to use when completing the Financial Analysis Worksheet. By having a baseline number of admissions/visits, the determination of the VTF, as well as the estimated costs and savings should be easier and more accurate.

## **2. Sample Case Study of Partnership Conversion RSA**

This example involves the conversion of a Partnership agreement for outpatient Pediatric services. The process for evaluating this type of agreement is a little more simplified since there was a baseline for the workload and marginal expenditures associated with the Partnership.

The agreement existed in the DCP and all of the Partnership visits were in the DCP data. The contractor's Category 8, RS expenditures, for this agreement were projected to be \$325,000. The aggregate total spent on RS to date was \$1,500,000 which was under the BAFO total proposed amount to be spent on RS. Therefore, the agreement was considered to be a part of the up-front savings associated with the contractor's reduced bid price and it was appropriate to give the contractor 100% "workload credit" for this RSA when evaluating the agreement with the Financial Analysis Worksheet. Since the Partnership had already been in existence and a baseline established for workload, the contractor and government agreed that the VTF should be minimal, and in this case used a VTF of 1.1. The MTF's marginal

expenditures were estimated to be \$125,000. The estimate was developed using the MEPRS data that existed from the current Partnership. The estimated visits enabled by the RSA were also established using the current workload associated with the Partnership. The workload was expected to be 8,000 ADD and 14,500 NADD at an average cost per visit of \$35. The agreement was evaluated using an 80-20 split for any residual gains as a result of the RSA. Appendix E contains the results of the FAW based on these assumptions and cost and workload estimates. The FAW is summarized in the next section.

*a. Financial Analysis Worksheet Results*

(1) Section I: Assumed Savings Reflected in BAFO. This section determined the amount of Resource Sharing Savings (costs avoided) already reflected in the proposed bid price assumptions. The contractor expected to spend approximately \$325,000 in Category 8, resource sharing expenditures, under this RSA. The assumed savings to cost ratio that was used to develop the resource sharing trend factor in the original bid price was 2.2. As a result the expected savings (cost avoided) for this agreement was \$715,000 ( $\$325,000 \times 2.2$ ). The net savings (cost avoided) already reflected in the bid price was \$390,000, which is the gross savings of \$715,000 minus the cost of the RSA, \$325,000.

(2) Section II: "O" Factor Impact on Bid Price Adjustment. This section estimated the impact of the RSA on MTF utilization (i.e., "O" factor). Since the contractor was given 100% workload credit for this RSA there was no impact on the "O" factor as a result of this agreement. If the agreement had provided only partial workload credit to the contractor then there would have been a decrease in the "O" factor since the MTF workload would not be totally offset by the contractor's workload credit.

(3) Section III: Impact on CHAMPUS Claims Costs. This section estimated the actual savings (CHAMPUS cost avoided) as a result of the RSA. In this agreement the workload enabled by this RSA was estimated to be 8,000 ADD and 14,500 NADD. Using the VTF of 1.1 the number of CHAMPUS visits avoided was 7,273 ADD and 13,182 NADD. Through the contractor's cost analysis it was determined that the estimated CHAMPUS costs avoided were going to be \$787,500, before considering the VTF. Dividing the total estimated costs avoided (without VTF) by the total number of MTF visits enabled by the RSA equals the average government cost per unit for CHAMPUS visits avoided of \$35 per visit for both ADD and NADD. Then taking the VTF into consideration the estimated CHAMPUS costs avoided were determined to be (7,273 ADD visits x \$35) \$254,545 plus (13,182 NADD visits x \$35) \$461,364 for a total of \$715,909.

(4) Section IV: Risk Sharing Impact. This section addressed the residual gain or risk sharing impact of the RSA. In this agreement the government shared in 80% of the risk and the contractor shared in 20% of the risk. As stated above the contractor's Category 8, RS expenditures, were estimated to be \$325,000. The net decrease in actual CHAMPUS costs is equal to the estimated CHAMPUS costs avoided (calculated in Section III) minus the contractor's RS expenditures or  $\$715,909 - \$325,000 = \underline{\$390,909}$ . The amount of savings (costs avoided) reflected in the up-front bid price (calculated in Section I) is then subtracted to calculate the residual gain to be shared between the government and the contractor,  $\$390,909 - \$390,000 = \underline{\$909}$ . The government and contractor then split the \$909 using the 80% -20% risk sharing guidelines established.

The resulting government gain is \$727 ( $80\% \times \$909$ ) and the resulting contractor gain is \$182 ( $20\% \times \$909$ ).

(5) Section V: Results of Analysis. This section provided the final results of the analysis concerning the check of contractor workload credit and cost-effectiveness from the MHSS perspective. The analysis showed that the contractor's initial contractor RS expenditures, \$325,000, and the resulting savings were already included in the BAFO price. The contractor's residual gain was calculated to be \$182 which represented a residual profit rate of 0.06%. The contractor's proposed profit rate for the overall health care costs from the BAFO was 3.5%. Since the RS expenditures and savings (costs avoided) were determined to be reflected in the BAFO price, it was appropriate to give the contractor 100% workload credit for this RSA. If the expenditures and savings were not a part of the BAFO price the contractor's residual profit rate on any gain associated with an RSA should not exceed the proposed profit rate for overall health care costs, in this case 3.5%. The analysis for cost-effectiveness took the projected MTF marginal expenditures, \$125,000, and subtracted the costs from the projected government gain to calculate the net government savings (cost avoided) under the RSA. The projected government gain is the up-front bid price savings plus 80% of the residual savings associated with the RSA,  $(\$390,000 + \$727) = \$390,727$ . The net government savings is expected to be  $\$390,727 - \$125,000 = \$265,727$ . Government gains exceed government expenditures; therefore the agreement yields a "yes" answer to the cost-effectiveness question.

This type of RSA is probably the simplest one to implement and evaluate for cost-effectiveness because the service is already being provided under the

Partnership and the MTF and contractor have baseline data on the patient and ancillary services workload to use in the analysis. However, MTFs must be careful to not assume that just because a Partnership was in place that an RSA for the same services will be cost-effective.

#### **E. SUMMARY**

This chapter presented the actual process of identifying and evaluating the different types of RSAs through illustrative examples and revealed how the different agreements affect the cost of the MCSC. Table 3 on the following page summarizes the key computations for the three different cases discussed in this chapter. This data is found in the text as well as detailed in Appendices C, D, and E.

Note that the major parts of each case are the gains to the government and the contractor. In each case both parties are expected to gain from the RSA. It should also be noted that the contractor and or government may in certain instances be willing to incur a loss. For example, to meet the BAFO's Category 8 RS expenditures the contractor may agree to an RSA of agree to less workload credit. In the case of the government, an MTF may enter into an agreement that may incur a loss due to limited access of health care in a rural area, due to a readiness requirement, or in order to support a General Medical Education program.

<b>CASE STUDY</b>	<b>Cost Avoidance</b>	<b>CHAMPUS Recapture</b>	<b>Partnership Conversion</b>
<u>Calculations of BAFO Net Savings for RSAs</u>			
Proposed Category 8 RS Expenditures	(\$97,891)	(\$95,000)	(\$325,000)
Savings:Cost Ratio	2.2	N/A	2.2
Gross Savings in Bid Price	\$215,360	N/A	\$715,000
Net Savings in Bid Price (Gross Savings-RS Exp.)	\$117,469	N/A	\$390,000
Included in BAFO Spending Assumptions	YES	NO	YES
<u>Calculation of Residual CHAMPUS Gain</u>			
CHAMPUS Cat. 1-7 Costs Avoided	\$269,325	\$123,750	\$715,909
Less: Cat. 8 RS Expenditures	(\$97,891)	(\$95,000)	(\$325,000)
Net Decrease in CHAMPUS Costs	\$171,434	\$28,750	\$390,909
Less: Net Savings in BAFO Price	(\$117,469)	N/A	(\$390,000)
Less: Decrease in Cat. 1-7 Costs Due to "O" Factor Adjustment	\$0	(\$18,337)	\$0
Residual CHAMPUS Gain to be Shared	<b>\$53,965</b>	<b>\$10,413</b>	<b>\$909</b>
<u>Calculation of Net Government MHSS Savings</u>			
Add: Government Savings from "O" Factor Adjustment	\$0	\$18,337	\$0
Add: Gov't Share of Residual CHAMPUS Gain (80%)	\$43,172	\$8,330	\$727
Add: Projected Gov't Gain in BAFO Price	\$117,469	\$0	\$390,000
Less: MTF Marginal Costs	(\$8,540)	(\$1,500)	(\$125,000)
Net Government MHSS Savings	<b>\$152,101</b>	<b>\$25,167</b>	<b>\$265,727</b>
Contractor Share of CHAMPUS Gain (20%)	<b>\$10,793</b>	<b>\$2,083</b>	<b>\$182</b>

Table 3. Summary of Key Computations for 3 Cases



## **V. SUMMARY AND CONCLUSION**

### **A. SUMMARY**

This research examined and evaluated the Resource Sharing program contained in the MCSC. The program was established as a part of the TRICARE MCSCs to provide a means to reduce CHAMPUS health care costs by enhancing the capabilities of the MTF.

The research was designed to address the current process for identifying, evaluating, and utilizing RSAs and how RSAs affect the costs of the MCSC. We identified the roles of the MTF, Contractor, and Lead Agent in the RSA process and identified the key elements and assumptions utilized in evaluating the different types of RSAs.

Chapter II provided background information on civilian managed care programs, an overview of the MHSS, and introduced DOD's managed care program, TRICARE. Next, in Chapter III we presented a detailed overview of the Resource Sharing program that identified the key elements of RSAs in the MCSC and documented the process for identifying and evaluating RSAs for cost-effectiveness. Lastly, in Chapter IV we illustrated the application of RSAs through the use of case studies for the three types of RSAs. The case studies provided an illustrative method for distinguishing the differences between the types of RSAs and how to interpret and use the FAW.

### **B. CONCLUSION**

The analysis revealed some areas of concern associated with the RS program. These concerns involve certain key elements of RS such as, bid price savings, MTF incentives, standardized training, workload credit, marginal costs and volume trade-off factors.

In addition it has been demonstrated that the FAW analysis relies on a series of key cost and workload estimates and assumptions to determine the cost-effectiveness of all three types of internal RSAs. Since the cost-effectiveness of an RSA is based on estimates and assumptions it is apparent that the monitoring of RSAs is key once the RSA is in place. This section provides a discussion of the major concerns of the RS program and the importance of monitoring RSA agreements for cost-effectiveness once in place.

## **1. Areas of Concern and Recommendations**

### ***a. Bid Price Savings***

There is some question among MTFs as to whether the up-front bid price savings should be considered for agreements that involve the replacement of an MTF provider or involve new workload. The argument is that there were no previous CHAMPUS costs associated with either of these type of agreements so how can there be savings. In addition, these requirements were probably not included in the contractor's resource sharing plan so how could the contractor have included these services in the bid price savings associated with the aggregate spending assumptions in the BAFO for Category 8 costs?

According to Kennell and Associates "cost savings" and "costs avoided" are used interchangeably in determining the cost-effectiveness of an RSA. In this type of agreements there may not be an actual savings from previous costs but there will be significant CHAMPUS costs avoided as a result of the RSA. There are also no guidelines on which type of agreements should be considered a part of the up-front bid price reduction. Although the contractor is required to submit a resource sharing plan the agreements do not necessarily have to be a part of the plan to be considered a part of the reduced bid price.

Thus, when evaluating RSA cost-effectiveness, RSA proposals should reflect the savings associated with the contractor's bid price reduction until the contractor reaches the Category 8 expenditures for RS (Kennel and Associates, 1996).

***b. MTF Incentives***

There are no direct incentives for the individual MTF to actively pursue RSAs.

While the MTF should be cooperating with the contractor in identifying and implementing potential RSAs there are no direct monetary savings given to the MTF for the RS program. The MCSC is for the entire HSR and gains and losses in BPA apply to the HSR not particular MTFs. In addition to no direct savings, the MTF is expected to fund the marginal expenditures associated with any potential RSAs out of their existing operating budget or request Service funds. So not only are the MTFs not actually seeing any of the savings (or losses) but the MTF is incurring additional operating costs. All savings associated with RS are accumulated at the OASD(HA) level.

Efforts are currently under way to channel the RS savings to the three Services to provide funding to MTF Commanders for the marginal expenditures. It may be possible in the future to determine the specific impact of an MTF's RSA on the "O" factor and gain/loss sharing corridors and reward specific MTFs for their positive contribution at bid price adjustment. In addition to direct savings it is imperative that MTF commanders have a common focus on the overall goals of the MHSS. In the case of RS that goal is to optimize MTF resources while also decreasing CHAMPUS costs.

*c. Standardized Training*

There is no standardized training on the use of RSAs and their impact on the contract price. Several Health Service Regions have developed their own manuals on how to do RS but there is no OASD(HA) approved training on RSAs other than the user's manual developed by Kennell and Associates for the Financial Analysis Worksheet. With no standard training program there are often conflicting opinions on the interpretation of some of the contract policy and procedures for using RSAs. There are differences between the MCSCs, but the overall process for identifying and evaluating RSAs is for the most part the same among all HSRs. A training program is being implemented in January 1997 to address this issue. The Naval Postgraduate School has been contracted by OASD(HA) and the three military medical departments to develop and deliver a four day program to resource managers.

*d. Workload Credit*

When evaluating cost avoidance RSAs involving the replacement of an MTF provider some MTFs did not feel they should give the contractor "workload credit" and also incur a negative bid price adjustment due to decreased MTF utilization. This opinion accentuates the need for a standardized training program on the use of RSAs. All MTFs do not have a clear understanding of how the process works and the positive and negative effects of RS in relation to contract costs.

Closer analysis reveals that there will be a negative BPA regardless of whether the MTF uses an RSA or not. This is due to a decrease in MTF utilization as a result of losing a provider for services that was included in the DCP. Even though some MTFs do not

feel it is in their best interest to enter into this type of agreement, potential government savings may exist.

It is assumed that the health care services in question can be provided in the MTF at a lower cost using an RSA than under TRICARE thereby reducing the overall health care costs of the contractor.

*e. Marginal Costs and Volume Trade-Off Factor*

The MHSS does not have a patient level cost accounting system. As a result MEPRS is currently the only system to use when estimating the marginal costs of an additional patient. There is some concern that MEPRS may not provide the most useful information for determining cost per patient but it is currently the best information system available in the MHSS.

There is currently no method for determining the appropriate VTF when evaluating an RSA. It is developed based on rough estimates and assumptions made by the contractor and MTF. In addition, it is difficult to monitor once the RSA is in place due to the time lag in CHAMPUS data.

*f. MTF Utilization or "O" Factor*

MTFs are not able to determine the impact on BPA as a result of implementing an RSA that replaces a lost provider or performs new workload. While we know the "O" factor will increase causing the contractor's cost to increase we do not know by how much. OASD(HA)'s contractor, Kennell and Associates, has developed a desktop model to conduct informal BPAs which would assist MTFs in determining the cost impact when evaluating RSAs.

This model is being tested within the MHSS and is expected to be disseminated to all HSRs.

*g. Financial Analysis Worksheet*

The Financial Analysis Worksheet does not distinguish between the different types of RSAs for evaluation purposes. This is a concern that has already been brought to the attention of OASD(HA) and they have developed a new worksheet that determines the type of agreement being requested before proceeding with the analysis. The new worksheet is being tested in two of the HSRs and if it is determined to be more beneficial than the current worksheet it will be disseminated to all HSRs.

In the MCSC it states that the MTF will complete the Financial Analysis Worksheet. In the two of the HSRs the MTFs were not completing the worksheet themselves but were providing the contractor with the relevant workload and cost information for completing the FAW. Although the results of the contractor's worksheet were carefully reviewed and analyzed by the MTF and Lead Agent, independent worksheets were not completed. The main reason given for the MTFs not completing a worksheet was the lack of personnel and necessary training to determine estimates and assumptions when completing the worksheet. In most cases the MTF's Managed Care Departments had only one person responsible for RSAs and in some cases the individual had other duties as well.

**2. Monitoring Resource Sharing Agreements**

In Chapter III we touched on the importance of monitoring RSAs. The analysis completed in Chapter IV has shown that the determination of cost-effectiveness is based almost entirely on estimates and assumptions made by the MTF and contractor. These estimates and assumptions include: the savings-to-cost ratio in the BAFO, the contractor's

Category 8 RS expenditures, the VTF, the MTF's marginal expenditures, the estimated workload enabled by the RSA, and the estimated cost per beneficiary category. By varying any one of these factors the RSA has the potential to go from one initially seen as cost-effective to both parties to one which may not be cost-effective to the government, the contractor or both.

For example, if we go back to Table 3 and look at the "cost avoidance" case study we see that the net government savings is expected to be \$152,101 and the contractor's share of the CHAMPUS gain is \$10,793. This is based on a savings-to-cost ratio of 2.2, \$97,891 in Category 8 RS expenditures, a VTF of 1.2, MTF marginal expenditures of \$8,540, 439 ADD and 695 NADD visits, and an average cost of \$285 per visit for both ADD and NADD. If we change the VTF to 2.5 and increase the MTF marginal expenditures to \$15,000 we get a totally different result in MHSS savings and contractor gains. The net government savings are now expected to be \$33,602 and there is no CHAMPUS gain to be shared, only a loss of \$17,217.

In another scenario we can show the importance of tracking the estimated workload to be enabled by the RSA. The "Partnership conversion" case study (see Table 3) estimated the workload enabled by the RSA to be 8,000 ADD and 14,500 NADD. These estimates coupled with the estimates and assumptions of the key factors discussed above elicited net government savings of \$265,727 and a share of the CHAMPUS gain in the amount of \$182 to the contractor. If at the end of the period the workload was actually only 5,000 ADD and 10,000 NADD, and all other estimates and assumptions remained the same, the government savings would have been \$74,818 and the contractor would have incurred a loss of \$47,545.

While the RSA still produces a savings of \$74,818 for the government it is a dramatic decrease from the anticipated savings of \$265,727.

The above examples illustrate the importance of the MTF and contractor monitoring and executing the RSA once it is in place. As stated above all previous analysis was completed using estimates and assumptions, therefore monitoring becomes a key issue in tracking the cost-effectiveness of the agreement. As mentioned in Chapter III there is no OASD(HA) standardized method for HSRs to use in monitoring RSAs. The use of current information systems, and possibly the development of new information systems is the key to developing a good monitoring program for tracking workload and cost estimates, as well as changes in CHAMPUS claims data as a result of an RSA.

### **3. Conclusion**

The findings of our research indicate that the RS is a viable program that can be beneficial to both the government and contractor. However, due to the complex nature of the MCSCs it is apparent that there needs to be some form of standardized education on the concept of RS and the effects RS has on the bid price, specifically focusing on the monitoring of RSAs once they are in place. The FAW can easily be manipulated by varying the cost and workload estimates and assumptions in order to make the agreement seem cost-effective. Therefore, monitoring of the agreement once in place to ensure the cost and workload estimates are on track and assumptions are holding true is imperative to a truly cost-effective RSA.

Resource sharing exists primarily as a result of the government requirement that potential contractor's reduce their bid price by an amount anticipated to be saved through



using RSAs. As a result, there is an implied contract between the government and contractor to utilize RSAs when they are deemed cost-effective in order to realize the anticipated cost savings. While the structure of the current MCSCs require the use of RSAs to realize these up front cost savings future versions of the MCSC are expected to contain little or no provisions for RSAs.

### **C. AREAS FOR FURTHER RESEARCH**

The focus of this research was to examine and evaluate the current process for identifying, evaluating, and utilizing RSAs and how they affect the costs of the MCSC. Our research uncovered some potential areas of additional research that were not covered in this thesis due to the recent development of the concept of RS and the lack of current data on actual RSAs. The items below may warrant additional research:

- Conduct an analysis of an actual RSA that has been in place for over a year and use the FAW to determine if the agreement was actually cost-effective.
- Examine how RSAs are being monitored in different MTFs and develop some type of standardized method for monitoring RSAs. This would include determining the information systems required for monitoring RSAs.
- Conduct an analysis on how MEPRS is utilized to estimate an MTF's marginal costs for an RSA and then compare the estimates with the actual marginal costs associated with the RSA.



## **APPENDIX A. GUIDELINES FOR WORKLOAD REPORTING**

## Guidelines for Resource Sharing Workload Reporting

### Background

The guidelines provided below are intended to provide the contractor and MTF personnel with a common basis for determining the full impact of resource sharing activities on MTF workload, measured in terms of admissions and outpatient visits. The "full credit" workload determinations made on the basis of these guidelines are intended to be used as a starting point for negotiations between the contractor and the MTF concerning the percentage of the full-credit workload which should be reported to the Contracting Officer for use in the bid price adjustment process described in Section G-5.g(2). In accordance with Section C-8.f(4)(a) 3, both the full-credit workload and the number of admissions and outpatient visits credited to each agreement shall be certified by the MTF commander or designee and reported to the Contracting Officer on a monthly basis during the health care delivery periods of the contract.

### Key Question

The key question which these guidelines are intended to answer for each agreement is this:

**What is the number of admissions and outpatient visits, reported by the MTF under MEPRS, which would not have been accomplished without resource sharing?**

### Definitions

The following definitions apply to the guidelines presented in this document:

- 1) **Agreement.** Unless otherwise specified, refers to a resource sharing agreement entered into by the contractor and the MTF Commander.
- 2) **CHAMPUS Patients.** Patients who are eligible for benefits under the CHAMPUS program.
- 3) **Non-CHAMPUS Patients.** Patients who are not eligible for benefits under the CHAMPUS program.
- 4) **Personnel.** Personnel in general, whether providers or support staff.
- 5) **Project.** A set of associated agreements which combine to provide a service or group of services in a given clinical area. For example, an operating room project might include separate agreements for anesthesiology, OR nurses, and recovery room nurses.

- 6) **Providers.** Health care personnel who are granted privileges by the MTF Commander to provide patient care at the MTF. Examples are physicians, nurse anesthetists, podiatrists, psychologists, nurse practitioners, social workers, etc.
- 7) **Workload.** In the context of this document, workload generally refers to admissions or outpatient visits as recorded by the MTF.

## Guidelines

- 1) Only visits and admissions for CHAMPUS-eligible patients performed as a direct result of resource sharing agreements will be counted as resource sharing workload. Counts will be based on the same definitions used by the MTFs for visits and admissions, regardless of how the service performed is defined for purposes of CHAMPUS reimbursement. The MEPRS Manual provides the relevant definitions of visits and admissions.

**Examples:** 1) A physician office visit performed by a resource sharing provider is counted as a visit. 2) A surgery performed by a resource sharing provider is counted as an admission if the patient is admitted for that surgical procedure. 3) A mammogram or MRI generally will not be counted as a visit, even though it is a service which would be paid for under CHAMPUS, because it is not counted as a visit by the MTF. (See number 8 below for an exception to this rule.) 4) A telephone consult made by a resource sharing provider may be counted as a visit, if it is counted as a visit by the MTF, even though it might not be reimbursed under CHAMPUS (or as part of a resource sharing agreement). 5) "Same day surgeries," where an admission and discharge actually take place will be counted as admissions. 6) "Ambulatory surgeries," where no admission takes place, will be counted as visits. 7) Procedures, such as endoscopies, colonoscopies, and outpatient podiatry procedures normally performed in a physician office or clinic setting will be counted as visits; however, if for some reason a patient is admitted to have such a procedure performed, it may be counted as an admission, if the MTF counts it as an admission.

- 2) Services performed by resource sharing providers for non-CHAMPUS patients will be paid for by the MTF in accordance with the terms of the agreement. Workload and costs associated with the provision of services to non-CHAMPUS patients will not be credited to the resource sharing agreement.
- 3) If the MTF has designated resource sharing operating room suites, all workload for CHAMPUS-eligible patients performed in those suites will be counted as admissions or visits (See Note 2, immediately below), according to definitions used by the MTF, and credited as workload to the

resource sharing agreement. The same rule applies for any unit or activity which is established and maintained as a direct result of resource sharing, even if some MTF personnel also participate in the activities of the unit.

**Examples:** 1) A designated CHAMPUS operating room where anesthesia and nursing services are supplied through resource sharing, even though OR techs are provided by the MTF and surgeries are performed by MTF providers. 2) A pediatric intensive care unit established and maintained through resource sharing, even though some of the nursing staff is provided by the MTF.

**Notes:** 1) A necessary condition for this guideline to apply is that the unit or activity and the associated CHAMPUS workload would not exist in the absence of the resource sharing agreement. If this is not the case, then the proportional allocation guideline in 5) below applies. 2) In the OR example above, admissions and outpatient visits which occur at the MTF because of the agreement may be counted even though the workload units reported under MEPRS for the operating room itself may not be admissions or visits, provided that the admissions or visits reported under the agreement are reported under MEPRS somewhere, are not reported as resource sharing workload in conjunction with another agreement, and would not have occurred without the agreement.

- 4) If resource sharing provides the entire staff for a nursing unit or other activity, then all CHAMPUS admissions or visits performed as a result of that agreement may be counted as resource sharing workload. Services by resource sharing personnel performed for non-CHAMPUS patients on such a unit will be paid for by the MTF according to the terms and conditions of the agreement, and the costs associated with that care will not be counted as health care costs under the contract.

**Example:** A nursing unit staffed entirely by resource sharing personnel. All CHAMPUS patients would be counted as admissions (unless the admission was counted under another agreement). Costs associated with services to non-CHAMPUS patients, if any, would be reimbursed by the MTF. All resource sharing costs, except those reimbursed by the MTF for non-CHAMPUS patients, would be allowed as health care costs under the contract.

- 5) When resource sharing personnel staff only a portion of a nursing unit or other activity in which MTF and resource sharing personnel work as part of a patient care team providing care to all classes of patients on the unit, workload performed on the unit will be credited to the resource sharing agreement in proportion to the relative contribution of resource sharing personnel to the production of the workload on that unit. This generally be done in proportion to the percentage of staff provided to the unit through resource sharing, except that the number of units of workload so

calculated may not exceed the actual number of units provided for CHAMPUS patients on the unit.

**Example:** Suppose there are 100 admissions to a nursing unit in a given month, 60 of which are CHAMPUS patients and that 50% of the staffing of the unit is provided through a resource sharing agreement. Then 50 of the admissions may be counted as resource sharing admissions, and all costs associated with the agreement may be counted as health care costs.

**Note:** In applying this guideline, it may be necessary to specify in the agreement on what basis the proportional counting will take place. For example, in the above illustration, the resource sharing agreement may supply 75% of the RNs, 30% of the ward clerks and 25% of the LVNs, for a total of 50% of the ward's personnel, and these may be distributed differently on different shifts and on different days. Although the average coverage may be 50% of the staffing of the unit, it may be that the number of CHAMPUS patients that can be cared for is dependent primarily on the number of RNs present. In such a situation, the proportion used for allocating CHAMPUS admissions to the unit may be weighted more toward the proportion of RN coverage, if this is specified in the agreement. The guiding principle should be how the various types of resources supplied affect the volume of CHAMPUS workload. In no case may percentages of different classes of personnel be added together to achieve a result (e.g., 20% of the LVNs and 30% of the RNs would not allow the contractor to take credit for 50% of the workload on the unit, unless this actually represented 50% of the staff of the unit).

- 6) In the case of a resource sharing agreement in which equipment is the only resource provided, the terms of the agreement, as they pertain to counting of workload, must be approved by the Lead Agent in advance. If the equipment is clearly the primary enabling factor in producing the workload, then CHAMPUS visits and admissions performed using that equipment may be credited to the agreement. Care may be provided to non-CHAMPUS patients with the equipment without compensation by the MTF, as long as so doing does not affect the volume of services provided to CHAMPUS patients or otherwise result in increased costs to the contractor; however, an agreement may specify circumstances under which MTF reimbursement for use of the equipment for the care of non-CHAMPUS patients will be required. All contractor costs associated with equipment-only agreements may be counted as health care costs under the contract, except those which are paid by the MTF for care provided to non-CHAMPUS patients.

Examples: 1) A laparoscope supplied to increase the capability of the MTF to perform surgeries for CHAMPUS patients. 2) A laser to allow more ophthalmologic procedures to be performed. 3) A treadmill to allow more cardiology patients to be seen.

**Notes:** 1) An equipment-only agreement for a piece of durable equipment should have a specified term, and may specify a proportional rule for counting workload as agreed upon by the contractor and the MTF in consideration of the value of the equipment and its relative contribution to the production of workload. (For example, all surgeries performed with a resource sharing laparoscope might be counted as resource sharing workload for a period of one year, or one visit may be counted for every two visits conducted using a particular piece of equipment.) The intent here is to avoid a situation where, for a relatively small, one-time investment, the contractor may be credited with a large volume of workload for the duration of the contract. 2) Lead Agent approval is not required in the case of significant patient devices, such as artificial joints or pacemakers, agreements for which may be credited with the MTF workload unit applicable to the service enabled by the device.

- 7) When multiple resource sharing agreements are involved in the provision of services to the same patient for a single visit or admission, only one visit or admission will be counted as resource sharing workload. The MTF and the contractor involved must agree on procedures and internal controls to ensure that no multiple counting of resource sharing workload occurs.
- 8) As a general rule, resource sharing agreements should relate directly to admissions and visits which take place in the patient care work center to which the resources are supplied; however, this does not preclude agreements which include support services outside of that work center, such as an additional laboratory tech to support increased CHAMPUS workload at a clinic supported by resource sharing. Under such circumstances, workload shall be reported based on the impact of the resources supplied directly to the patient care work center, with no additional workload credited to the support functions. However, with the permission of the Lead Agent, agreements may be established which credit admissions or visits to a support service agreement based on the impact that agreement has on a patient care work center, if it can be clearly demonstrated that a resource sharing agreement is responsible for enabling a CHAMPUS visit or admission at the MTF (i.e., in the absence of the agreement, the visit or admission would not have occurred).

**Examples:** 1) An echo-cardiogram tech is supplied to a radiology department to allow more cardiology visits to take place. Cardiology visits for CHAMPUS-eligible patients enabled by this agreement may be counted as visits although the echo-cardiogram itself would not be counted as a visit by the MTF. 2) An MRI tech is provided through resource sharing to allow an orthopedic clinic to provide more visits for CHAMPUS-eligible patients.

**Notes:** 1) In all such situations the increased CHAMPUS workload attributable to the agreement may be credited to the agreement provided



that the admissions or visits would not otherwise have occurred, that they are not being counted in association with another resource sharing agreement, that the workload relationship and method of counting are specified in the agreement, and that the agreement has been approved by the Contracting Officer. All associated resource sharing costs may also be counted as health care costs, except those which are paid by the MTF for services to non-CHAMPUS patients in accordance with the terms of the agreement. 2) The current CHAMPUS Cooperative Care policy must be considered in applying this guideline, since, under it, a wide range of diagnostic CHAMPUS services may be provided under CHAMPUS, if the services are not available at the MTF, without disengaging the patient. Thus it is less likely that a valid argument can be made that the availability of a particular support service at the MTF is crucial to providing a particular type of visit at the MTF.

- 9) No workload will be credited to a resource sharing agreement solely on the basis of supplies provided. In general supplies will be considered as resources provided in support of a particular agreement involving personnel, or equipment, or both. Exceptions to this rule must be authorized by the Lead Agent.

**Examples:** 1) In an operating room supported by resource sharing personnel and supplies, workload will be credited based on the personnel assets provided; the supplies and associated costs will be considered to be in support of the workload performed by the personnel provided. 2) In a clinic staffed by a resource sharing provider, if the agreement covers the costs of prescription drugs prescribed by the provider, the drugs and costs associated with them will be considered in support of the provider agreement.

**Note:** This guideline does not apply to agreements for the provision of significant patient devices, such as artificial joints or pacemakers (see Note 2 under Guideline 6).

- 10) If the contractor and the MTF Commander agree that it is appropriate to do so, a proportional counting approach (providing less than one-to-one credit in terms of resource sharing workload, as indicated in Note 1 under Guideline 6 above) may be used in non-equipment agreements to avoid a disproportionate workload credit for a relatively minor resource sharing contribution; however, prior approval of the Lead Agent is required.

**Note:** Given that the workload credit reported for purposes of the bid price adjustment will be subject to negotiations in accordance with Section G-5.g(2), situations in which this guideline need be applied should be rare.

- 11) In conjunction with the foregoing guidelines, there must be a monthly certification of the impact of resource sharing workload on MTF workload, jointly prepared by the MTF and the contractor. Disputes will be resolved

by the Contracting Officer or a designated representative. The certification will summarize the number of admissions and visits credited to each individual project or agreement and the total number of admissions and visits enabled by resource sharing at the MTF during the month. Visits and admissions must be categorized by beneficiary type (i.e., ADD vs. NADD). These are the categories currently specified in the bid price adjustment process. Prenatal and postnatal OB visits must also be separately accounted for. (See attached format.) These jointly prepared and certified reports will form the basis for the resource sharing workload counts reported in the contractor's monthly resource sharing report and used in the bid price adjustment process. Each monthly report must be signed by designated MTF and contractor representatives.

**Cost Accounting Note:** Except where otherwise indicated above, all contractor health care costs associated with resource sharing workload reported in accordance with the above guidelines may be counted as health care costs under the contract.

**Implementation Note:** Full implementation of these guidelines will require specification in each agreement of the method of counting to be used. Given the complex nature of health care and the variety of settings in which it is provided, it is likely that not all present and future agreements are adequately addressed in the guidelines as written. If assistance in applying these guidelines is needed, the Contracting Officer's Representative (or the Alternate Contracting Officer's Representative for the appropriate Lead Agent Region) should be contacted. He or she will provide guidance or request further direction from the Contracting Officer.

**Format for Monthly Certification  
of Impact of Resource Sharing  
on MTF Workload**

MTF \_\_\_\_\_

Month of Report \_\_\_\_\_

Project /Agreement	Admissions		OB Visits*		Other Visits**	
	ADD	NADD	ADD	NADD	ADD	NADD
<b>Totals:</b>						

\* Pre-natal and post-natal obstetric outpatient visits assumed to be related to delivery. These visits are excluded from the resource sharing workload data because they are already included in the MTF OB visits which are deducted from total MTF visits in the bid price adjustment process.

\*\* Only outpatient visits as defined in the MEPRS Manual. Inpatient visits shall not be reported.



## **APPENDIX B. FINANCIAL ANALYSIS WORKSHEET (FAW)**

	A	B	C
1		MTF/CONTRACTOR INPUTS TO RESOURCE SHARING FINANCIAL WORKSHEET	
2		REGION DELTA	
3			
4		BOXED VALUES MUST BE ENTERED FIRST	
5			
6		VARIABLE	VALUE
7			
8		Note: For All Variables, If Proposed Change Will Be Limited To One Setting (Inpatient or Outpatient), Enter Zeroes for the Other Setting.	
9			
10	1.	Option Period	1
11			
12	2.	Expected Contractor Category 8 Expenditure Under This Resource Sharing Agreement	
13			
14		A. Total Contractor Category 8 Expenditure for CHAMPUS and Non-CHAMPUS Eligibles	\$226,682
15			
16		B. Contractor Category 8 Expenditure for Non-CHAMPUS Eligibles, If Any	\$0
17			
18		C. Contractor Category 8 Expenditure for CHAMPUS Eligibles Only (Used in Worksheet)	\$226,682
19			
20	3.	Projected MTF Marginal Expenditures Under RS Agreement	
21			
22		A. Total MTF Marginal Expenditures for Both CHAMPUS and Non-CHAMPUS Eligibles	\$67,609
23			
24		B. MTF Marginal Expenditures for Non-CHAMPUS Eligibles, If Any	\$0
25			
26		C. MTF Marginal Expenditures for CHAMPUS Eligibles Only (Used in Worksheet)	\$67,609
27			
28	4.	Contractor Resource Sharing Workload Credit Assumed in Analysis (May Need to Be Adjusted on an Iterative Basis Until Worksheet is Finalized)	100%
29			
30			
31	5.	Number of MTF Units Enabled By the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Units Which Would Not Occur in the Absence of the RS Agreement)	
32			
33			
34			
35		A. MTF Units for Both CHAMPUS and Non-CHAMPUS Eligibles	
36			
37		Inpatient Admissions	ADD 0
38			NADD 0
39			
40		Outpatient Visits	ADD 3,186
41			NADD 3,186
42			
43		B. MTF Units for Non-CHAMPUS Eligibles, If Any	
44			
45		Inpatient Admissions	ADD 0
46			NADD 0
47			
48		Outpatient Visits	ADD 0
49			NADD 0
50			
51		C. MTF Units for CHAMPUS Eligibles Only (Used in Worksheet)	
52			
53		Inpatient Admissions	ADD 0
54			NADD 0
55			
56		Outpatient Visits	ADD 3,186
57			NADD 3,186

	A	B	C
59	6.	Expected Government Risk Sharing Responsibility %	80%
60			
61		Expected Contractor Risk Sharing Responsibility % (100% - Government %)	20%
62			
63	7.	Assumed Volume Trade-Off Factor for Workload Expected Under This Agreement	
64			
65		Note: This is Used to Estimate CHAMPUS Avoidance. The VTF's Cannot Be Lower than 1.0.	
66		While the VTF Under Resource Sharing is Expected to Be Lower than the VTF for MTF Care	
67		Overall, the Following Official DoD VTF Estimates for MTF Care Overall May Be Helpful in	
68		Estimating These Inputs:	
69			
70			
71			
72			
73			
74			
75			
76			
77			
78			
79	8.	Average Government Cost Per Unit Avoided in CHAMPUS For Care Covered By Agreement	
80			
81		You Can Either Estimate Average Government Costs in the Worksheet (A) or Use Estimates	
82		Developed Elsewhere (B). Enter Zeroes in the Boxes for the Method (A or B) Not Used.	
83			
84		A. Estimating Average Government Costs in Worksheet	
85			
86		1. Total Government CHAMPUS Costs for Workload Affected	
87			
88			
89			
90			
91			
92			
93			
94			
95			
96			
97			
98			
99			
100			
101			
102			
103			
104			
105			
106			
107			
108			
109			
110			
111			
112			
113			
114			
115			
116			
117	9.	Sum of Projected Resource Sharing Expenditures for Agreements Already Approved--	\$0
118		To Be Supplied by Lead Agent	

	A	B	C	D	E	F	G
1	DATA AND ASSUMPTIONS FROM CONTRACT OR BAFO--PROVIDED BY DoD						
2	(Reflects April 1, 1996 start date for health care delivery)						
3							
4	REGION DELTA						
5							
6							
7	REGIONAL VARIABLE	DCP	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8							
9	Assumed Gross Savings:Cost Ratio		2.20	2.20	2.20	2.20	2.20
10	Used to Develop Resource						
11	Sharing Savings Trend Factor						
12							
13	Number of CHAMPUS Eligibles						
14	ADD	78,660	68,573	65,902	64,210	63,864	63,845
15	NADD	140,490	137,914	137,046	136,582	136,421	136,409
16							
17	[(M x P x Q) + (M x R x S) +						
18	(M x T x U)] for Cat. 1-3 Total						
19	ADD	\$258.53	\$257.36	\$263.65	\$272.50	\$282.64	
20	NADD	\$194.48	\$190.77	\$193.70	\$199.09	\$205.98	
21							
22	[(M x P x Q) + (M x R x S) +						
23	(M x T x U)] for Cat. 4-7 Total						
24	ADD	\$220.74	\$223.36	\$233.67	\$246.73	\$261.49	
25	NADD	\$291.89	\$289.25	\$297.89	\$310.37	\$325.42	
26							
27	NAS % of DCP Inpatient Costs						
28	ADD	52%					
29	NADD	27%					
30							
31	Number of NAS-Equivalents Without						
32	the Resource Sharing Agreement						
33	ADD	4,812	3,143	3,016	2,877	2,862	2,861
34	NADD	3,681	4,622	4,554	4,501	4,496	4,496
35							
36	CHAMPUS Outpatient Visits in						
37	the DCP						
38	ADD	222,499					
39	NADD	415,332					
40							
41	Volume Trade-Off Factor Assumed						
42	In Contract For Outpatient Visits						
43	(Used to Calculate "O" Factor)						
44	ADD	1.8					
45	NADD	2.8					
46							
47	Number of MTF Outpatient Visits						
48	(Non-OB, Non-Partnership) Without						
49	the Resource Sharing Agreement						
50	ADD	339,214	237,505	225,154	224,832	223,931	223,846
51	NADD	650,449	408,955	398,418	410,513	414,029	414,249
52							
53							
54	Proposed Profit Rate for	3.50%	3.53%	3.56%	3.57%	3.58%	
55	Overall Health Care Costs						
56							
57	Contractor's Aggregate Resource	\$12,855,323	\$12,446,990	\$13,162,671	\$13,999,121	\$14,854,106	
58	Sharing Expenditures Assumed in BAFO						



	A	B	C	D	E	F
1	<b>DETERMINING WHETHER THE PROPOSED RESOURCE SHARING EXPENDITURES ARE</b>					
2	<b>ALREADY INCLUDED IN THE CONTRACTOR'S AGGREGATE BAFO SPENDING ASSUMPTION</b>					
3						
4	<b>REGION DELTA</b>					
5						
6						
7		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8						
9	Contractor's Aggregate Resource	\$12,855,323	\$12,446,990	\$13,162,671	\$13,999,121	\$14,854,106
10	Sharing Expenditures Assumed in BAFO					
11						
12						
13	Sum of Projected Resource Sharing	\$0	\$0	\$0	\$0	\$0
14	Expenditures for Agreements Already					
15	Approved--To Be Supplied by Lead Agent					
16						
17						
18	Is Proposed Resource Sharing	YES	YES	YES	YES	YES
19	Agreement Already Included in					
20	the Contractor's Aggregate BAFO					
21	Spending Assumptions?					
22						

	A	B	C	D	E
1	<b>RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET</b>				
2	<b>REGION DELTA</b>				
3					
4					
5	I.	<b>Assumed Resource Savings Already Reflected in Proposed Bid Price Assumptions</b>			
6					
7					
8	A.	Expected Contractor Category 8 Expenditures for CHAMPUS Eligibles Under This Resource Sharing Agreement			\$226,682
9					
10	B.	Are Proposed Savings Already Included in Contractor's BAFO?			YES
11					
12	C.	Assumed Savings:Cost Ratio Used to Develop Resource Sharing Savings Trend Factor			2.2
13		in Original Bid Price for Categories 1-7			
14					
15	D.	Expected Savings in Cat. 1-7 for this Agreement, Consistent with Proposed Savings Trend Factor			\$498,700
16		and Assumed To Be Already Reflected in Original Bid Price for Categories 1-7			
17					
18	E.	<b>Net CHAMPUS Savings Assumed To Be Already Reflected in Contractor's BAFO</b>			<b>\$272,018</b>
19		<b>(Categories 1-7 Savings Minus Category 8 Expenditures)</b>			
20					

	A	B	C	D	E
23	II.	Impact of Cat. 1-7 Bid Price Adjustment for O Factor			
24					
25					
26		Note: O Factor calculations must be beneficiary-category specific.			
27			ADD	NADD	Total
28	A.	Bid Price Components Unaffected by RS Agreement:			
29					
30	1.	Number of CHAMPUS Eligibles in DCP (for the Region)	78,660	140,490	NA
31					
32	2.	Number of CHAMPUS Eligibles in Option Period (for the Region)	68,573	137,914	NA
33					
34	3.	[(M x P x Q) + (M x R x S) + (M x T x U)] for Categories 1-3 Total in Option Period (for the Region)	\$259	\$194	NA
35					
36	4.	[(M x P x Q) + (M x R x S) + (M x T x U)] for Categories 4-7 Total in Option Period (for the Region)	\$221	\$292	NA
37					
38	B.	Inpatient Resource Sharing Agreements: Calculation of O Factor Impact			
39					
40	1.	NAS % of DCP Inpatient Costs (Input for O Factor Formula, for the Region)	52%	27%	NA
41					
42	2.	Number of NAS-Equivalents in DCP (Input for O Factor Formula, for the Region)	4,812	3,681	NA
43					
44	3.	Number of NAS-Equivalents without the Resource Sharing Agreement in Option Period (Input for O Factor Formula, for the Region)	3,143	4,622	NA
45					
46					
47	4.	Inpatient O Factor without this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA
48					
49	5.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	0	0	NA
50					
51					
52					
53					
54	6.	Number of NAS-Equivalents with the Resource Sharing Agreement in Option Period, Before Contractor Workload Credit	3,143	4,622	NA
55					
56					
57	7.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period (Pending Confirmation of Acceptable Worksheet Results)	100%	100%	NA
58					
59					
60	8.	Number of NAS-Equivalents Credited to Resource Sharing Agreement in Option Period	0	0	NA
61					
62	9.	Number of NAS-Equivalents with the RS Agreement in Option Period, After Contractor Workload Credit	3,143	4,622	NA
63					
64	10.	Inpatient O Factor with this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA

	A	B	C	D	E
66	C.	Outpatient Resource Sharing Agreements: Calculation of O Factor Impact			
67					
68	1.	CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)	222,499	415,332	NA
69					
70	2.	MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)	339,214	650,449	NA
71					
72	3.	Number of MTF Outpatient Visits without the Resource Sharing Agreement in Option Period	237,505	408,955	NA
73		(Input for O Factor Formula, for the Region)			
74					
75	4.	Volume Trade-Off Factor for Outpatient Visits Assumed in Contract	1.8	2.8	
76					
77	5.	Outpatient O Factor without this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
78					
79	6.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	3,186	3,186	NA
80		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
81		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
82		Provided in Section J, Attachment 13)			
83					
84	7.	Number of MTF Outpatient Visits with the Resource Sharing Agreement in Option Period, Before	240,691	412,141	NA
85		Contractor Workload Credit			
86					
87	8.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period	100%	100%	NA
88		(Pending Confirmation of Acceptable Worksheet Results)			
89					
90	9.	Number of MTF Outpatient Visits Credited to Resource Sharing Agreement in Option Period	3,186	3,186	NA
91					
92	10.	Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit	237,505	408,955	NA
93					
94	11.	Outpatient O Factor with this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
95					
96	D.	Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any			
97					
98	1.	Inpatient CHAMPUS Costs (Categories 1 to 3)	\$0	\$0	\$0
99					
100	2.	Outpatient CHAMPUS Costs (Categories 4 to 7)	\$0	\$0	\$0
101					
102	3.	Total Change (Categories 1 to 7)	\$0	\$0	\$0
103					

	A	B	C	D	E
105	III.	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
111		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
112		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
113		Provided in Section J, Attachment 13)			
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	0	0	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$0	\$0	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$0	\$0	\$0
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	3,186	3,186	NA
126		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
127		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
128		Provided in Section J, Attachment 13)			
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.2	1.2	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	2,655	2,655	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$124	\$124	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$328,609	\$328,609	\$657,219
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$328,609	\$328,609	\$657,219
139					

	A	B	C	D	E
142	IV.	Risk Sharing Impact			
143					
144					
145	A.	Contractor's Resource Sharing Expenditures in Category 8 (For CHAMPUS Eligibles Only)			\$226,682
146					
147	B.	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Category 8 Costs)			\$430,537
148					
149	C.	Net Decrease in CHAMPUS Costs Already Reflected in Contractor's Total Bid Price			\$272,018
150		(Includes Effect of Assumed Resource Sharing Expenditures and Savings Trend Factor from BAFO)			
151					
152	D.	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any			\$0
153					
154	E.	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared			\$158,518
155		(Actual Net Decrease in Health Care Costs - Savings in BAFO Price - O Factor Adjustment)			
156					
157	F.	Expected Government Risk Sharing Responsibility Percentage			80%
158		(Lead Agent To Provide Guidance with Input from Contractor			
159		for This Assumption to Ensure Consistency within the Region)			
160					
161	G.	Expected Contractor Risk Sharing Responsibility Percentage			20%
162		(Lead Agent To Provide Guidance with Input from Contractor			
163		for This Assumption to Ensure Consistency within the Region)			
164					
165	H.	Resulting Government Gain Sharing Amount			\$126,815
166					
167	I.	Resulting Contractor Gain Sharing Amount			\$31,704
168					

	A	B	C	D	E
171	V.	RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS			
172					
173					
174	A.	Contractor Resource Sharing Workload Credit Assumed in Analysis (Above)			100%
175					
176	B.	Contractor's Resource Sharing Expenditures as Percent of Total Expenditures (Contractor + MTF Marginal)			77%
177		(For Information; Not Used in Worksheet Calculations)			
178					
179	C.	Analysis of Contractor Profit and Workload Credit:			
180					
181	1.	Contractor's Resource Sharing Expenditures			\$226,682
182		Are These Expenditures and the Resulting Savings Already Reflected in the Contractor's BAFO?			YES
183					
184	2.	Projected Actual Net Contractor Gain from Resource Sharing (Risk Sharing Result):			\$31,704
185		For Comparison in Judging Reasonable Workload Credit, vs. Profit Rate on Expenditures Only			
186		See Also Comparison of Contractor vs. Government Gains Under RS Agreement (Below)			
187					
188	3.	Projected Actual Contractor Resource Sharing Profit as Percent of Resource Sharing Expenditures			13.99%
189					
190	4.	Proposed Profit Rate for Overall Health Care Costs (from Contractor's BAFO)			3.50%
191					
192	5.	Is Proposed Contractor Workload Credit Appropriate?			YES
193		For Agreements Reflecting Expenditures and Resulting Savings Already Included in the Contractor's BAFO (See Part V.C.1),		(See Explanation at Left)	
194		100 Percent Workload Credit is Appropriate If the MHSS Cost-Effectiveness Requirement Is Also Satisfied. For Agreements			
195		Reflecting Expenditures and Resulting Savings Beyond Those Assumed in the Contractor's BAFO, the Projected Actual			
196		Contractor Profit Rate for Resource Sharing (See Part V.C.3) Should Be Approximately Equal to the Proposed Profit Rate			
197		for Overall Health Care Costs (Rounding to the Nearest Full Percentage Point) (See Part V.C.4)			
198					
199	D.	Analysis of Cost-Effectiveness for the Government from the MHSS Perspective			
200					
201	1.	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)			\$67,609
202					
203	2.	Projected Government Gain in CHAMPUS Under RS Agreement (Net Savings in BAFO Price +			\$398,833
204		Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)			
205					
206	3.	Net Government MHSS Savings Under RS Agreement			\$331,224
207					
208	4.	Do Government Gains Exceed Government Expenditures?			YES
209		If the Result in Part V.D.3 Is a Positive Value, Then Government Gains Exceed Government Costs			
210					
211	E.	Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement			
212					
213	1.	Total Projected Net Contractor Gain Under Resource Sharing Agreement			\$31,704
214					
215	2.	Total Projected Net Government Gain Under Resource Sharing Agreement			\$331,224
216					
217		NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO PART V.C.5 AND V.D.4 ARE BOTH "YES."			
218		IF THE RESPONSES TO BOTH QUESTIONS (PARTS V.C.5 AND V.D.4) ARE NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD			
219		CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.			
220		IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR,			
221		THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE			
222		PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).			





## **APPENDIX C. FAW FOR COST AVOIDANCE RSA**

	A	B	C	D	E	F
1	<b>DETERMINING WHETHER THE PROPOSED RESOURCE SHARING EXPENDITURES ARE</b>					
2	<b>ALREADY INCLUDED IN THE CONTRACTOR'S AGGREGATE BAFO SPENDING ASSUMPTION</b>					
3						
4	<b>REGION ALPHA</b>					
5						
6						
7		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8						
9	Contractor's Aggregate Resource	\$12,855,323	\$12,446,990	\$13,162,671	\$13,999,121	\$14,854,106
10	Sharing Expenditures Assumed in BAFO					
11						
12						
13	Sum of Projected Resource Sharing	\$250,000	\$0	\$0	\$0	\$0
14	Expenditures for Agreements Already					
15	Approved--To Be Supplied by Lead Agent					
16						
17						
18	Is Proposed Resource Sharing	YES	YES	YES	YES	YES
19	Agreement Already Included in					
20	the Contractor's Aggregate BAFO					
21	Spending Assumptions?					
22						

	A	B	C	D	E
1	<b>RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET</b>				
2	<b>REGION ALPHA</b>				
3					
4					
5	I.	<b>Assumed Resource Savings Already Reflected in Proposed Bid Price Assumptions</b>			
6					
7					
8	A.	Expected Contractor Category 8 Expenditures for CHAMPUS Eligibles Under This Resource Sharing Agreement			\$97,891
9					
10	B.	Are Proposed Savings Already Included in Contractor's BAFO?			YES
11					
12	C.	Assumed Savings:Cost Ratio Used to Develop Resource Sharing Savings Trend Factor			2.2
13		in Original Bid Price for Categories 1-7			
14					
15	D.	Expected Savings in Cat. 1-7 for this Agreement, Consistent with Proposed Savings Trend Factor			\$215,360
16		and Assumed To Be Already Reflected in Original Bid Price for Categories 1-7			
17					
18	E.	Net CHAMPUS Savings Assumed To Be Already Reflected in Contractor's BAFO			\$117,469
19		(Categories 1-7 Savings Minus Category 8 Expenditures)			
20					

	A	B	C	D	E
23	II.	Impact of Cat. 1-7 Bid Price Adjustment for O Factor			
24					
25					
26		Note: O Factor calculations must be beneficiary-category specific.			
27			ADD	NADD	Total
28	A.	Bid Price Components Unaffected by RS Agreement:			
29					
30	1.	Number of CHAMPUS Eligibles in DCP (for the Region)	78,660	140,490	NA
31					
32	2.	Number of CHAMPUS Eligibles in Option Period (for the Region)	68,573	137,914	NA
33					
34	3.	[(M x P x Q) + (M x R x S) + (M x T x U)] for Categories 1-3 Total in Option Period (for the Region)	\$259	\$194	NA
35					
36	4.	[(M x P x Q) + (M x R x S) + (M x T x U)] for Categories 4-7 Total in Option Period (for the Region)	\$221	\$292	NA
37					
38	B.	Inpatient Resource Sharing Agreements: Calculation of O Factor Impact			
39					
40	1.	NAS % of DCP Inpatient Costs (Input for O Factor Formula, for the Region)	52%	27%	NA
41					
42	2.	Number of NAS-Equivalents in DCP (Input for O Factor Formula, for the Region)	4,812	3,681	NA
43					
44	3.	Number of NAS-Equivalents without the Resource Sharing Agreement in Option Period (Input for O Factor Formula, for the Region)	3,143	4,622	NA
45					
46					
47	4.	Inpatient O Factor without this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA
48					
49	5.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Option Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines Provided in Section J, Attachment 13)	0	0	NA
50					
51					
52					
53					
54	6.	Number of NAS-Equivalents with the Resource Sharing Agreement in Option Period, Before Contractor Workload Credit	3,143	4,622	NA
55					
56					
57	7.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period (Pending Confirmation of Acceptable Worksheet Results)	100%	100%	NA
58					
59					
60	8.	Number of NAS-Equivalents Credited to Resource Sharing Agreement in Option Period	0	0	NA
61					
62	9.	Number of NAS-Equivalents with the RS Agreement in Option Period, After Contractor Workload Credit	3,143	4,622	NA
63					
64	10.	Inpatient O Factor with this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA

	A	B	C	D	E
66	C.	Outpatient Resource Sharing Agreements: Calculation of O Factor Impact			
67					
68	1.	CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)	222,499	415,332	NA
69					
70	2.	MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)	339,214	650,449	NA
71					
72	3.	Number of MTF Outpatient Visits without the Resource Sharing Agreement in Option Period	237,505	408,955	NA
73		(Input for O Factor Formula, for the Region)			
74					
75	4.	Volume Trade-Off Factor for Outpatient Visits Assumed in Contract	1.8	2.8	
76					
77	5.	Outpatient O Factor without this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
78					
79	6.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	439	695	NA
80		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
81		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
82		Provided in Section J, Attachment 13)			
83					
84	7.	Number of MTF Outpatient Visits with the Resource Sharing Agreement in Option Period, Before	237,944	409,650	NA
85		Contractor Workload Credit			
86					
87	8.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period	100%	100%	NA
88		(Pending Confirmation of Acceptable Worksheet Results)			
89					
90	9.	Number of MTF Outpatient Visits Credited to Resource Sharing Agreement in Option Period	439	695	NA
91					
92	10.	Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit	237,505	408,955	NA
93					
94	11.	Outpatient O Factor with this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
95					
96	D.	Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any			
97					
98	1.	Inpatient CHAMPUS Costs (Categories 1 to 3)	\$0	\$0	\$0
99					
100	2.	Outpatient CHAMPUS Costs (Categories 4 to 7)	\$0	\$0	\$0
101					
102	3.	Total Change (Categories 1 to 7)	\$0	\$0	\$0
103					

	A	B	C	D	E
105	III.	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
111		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
112		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
113		Provided in Section J, Attachment 13)			
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	0	0	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$0	\$0	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$0	\$0	\$0
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	439	695	NA
126		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
127		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
128		Provided in Section J, Attachment 13)			
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.2	1.2	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	366	579	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$285	\$285	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$104,263	\$165,063	\$269,325
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$104,263	\$165,063	\$269,325
139					

	A	B	C	D	E
142	IV.	Risk Sharing Impact			
143					
144					
145	A.	Contractor's Resource Sharing Expenditures in Category 8 (For CHAMPUS Eligibles Only)			\$97,891
146					
147	B.	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Category 8 Costs)			\$171,434
148					
149	C.	Net Decrease in CHAMPUS Costs Already Reflected in Contractor's Total Bid Price			\$117,469
150		(Includes Effect of Assumed Resource Sharing Expenditures and Savings Trend Factor from BAFO)			
151					
152	D.	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any			\$0
153					
154	E.	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared			\$53,965
155		(Actual Net Decrease in Health Care Costs - Savings in BAFO Price - O Factor Adjustment)			
156					
157	F.	Expected Government Risk Sharing Responsibility Percentage			80%
158		(Lead Agent To Provide Guidance with Input from Contractor			
159		for This Assumption to Ensure Consistency within the Region)			
160					
161	G.	Expected Contractor Risk Sharing Responsibility Percentage			20%
162		(Lead Agent To Provide Guidance with Input from Contractor			
163		for This Assumption to Ensure Consistency within the Region)			
164					
165	H.	Resulting Government Gain Sharing Amount			\$43,172
166					
167	I.	Resulting Contractor Gain Sharing Amount			\$10,793
168					

	A	B	C	D	E
171	V.	RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS			
172					
173					
174	A.	Contractor Resource Sharing Workload Credit Assumed in Analysis (Above)			100%
175					
176	B.	Contractor's Resource Sharing Expenditures as Percent of Total Expenditures (Contractor + MTF Marginal)			92%
177		(For Information; Not Used in Worksheet Calculations)			
178					
179	C.	Analysis of Contractor Profit and Workload Credit:			
180					
181	1.	Contractor's Resource Sharing Expenditures			\$97,891
182		Are These Expenditures and the Resulting Savings Already Reflected in the Contractor's BAFO?			YES
183					
184	2.	Projected Actual Net Contractor Gain from Resource Sharing (Risk Sharing Result):			\$10,793
185		For Comparison in Judging Reasonable Workload Credit, vs. Profit Rate on Expenditures Only			
186		See Also Comparison of Contractor vs. Government Gains Under RS Agreement (Below)			
187					
188	3.	Projected Actual Contractor Resource Sharing Profit as Percent of Resource Sharing Expenditures			11.03%
189					
190	4.	Proposed Profit Rate for Overall Health Care Costs (from Contractor's BAFO)			3.50%
191					
192	5.	Is Proposed Contractor Workload Credit Appropriate?			YES
193		For Agreements Reflecting Expenditures and Resulting Savings Already Included in the Contractor's BAFO (See Part V.C.1),		(See Explanation at Left)	
194		100 Percent Workload Credit is Appropriate If the MHSS Cost-Effectiveness Requirement is Also Satisfied. For Agreements			
195		Reflecting Expenditures and Resulting Savings Beyond Those Assumed in the Contractor's BAFO, the Projected Actual			
196		Contractor Profit Rate for Resource Sharing (See Part V.C.3) Should Be Approximately Equal to the Proposed Profit Rate			
197		for Overall Health Care Costs (Rounding to the Nearest Full Percentage Point) (See Part V.C.4)			
198					
199	D.	Analysis of Cost-Effectiveness for the Government from the MHSS Perspective			
200					
201	1.	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)			\$8,540
202					
203	2.	Projected Government Gain in CHAMPUS Under RS Agreement (Net Savings in BAFO Price +			\$160,641
204		Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)			
205					
206	3.	Net Government MHSS Savings Under RS Agreement			\$152,101
207					
208	4.	Do Government Gains Exceed Government Expenditures?			YES
209		If the Result in Part V.D.3 is a Positive Value, Then Government Gains Exceed Government Costs			
210					
211	E.	Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement			
212					
213	1.	Total Projected Net Contractor Gain Under Resource Sharing Agreement			\$10,793
214					
215	2.	Total Projected Net Government Gain Under Resource Sharing Agreement			\$152,101
216					
217		NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO PART V.C.5 AND V.D.4 ARE BOTH "YES."			
218		IF THE RESPONSES TO BOTH QUESTIONS (PARTS V.C.5 AND V.D.4) ARE NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD			
219		CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.			
220		IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR,			
221		THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE			
222		PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).			



## **APPENDIX D. FAW FOR CHAMPUS RECAPTURE RSA**

	A	B	C	D	E	F
1	<b>DETERMINING WHETHER THE PROPOSED RESOURCE SHARING EXPENDITURES ARE</b>					
2	<b>ALREADY INCLUDED IN THE CONTRACTOR'S AGGREGATE BAFO SPENDING ASSUMPTION</b>					
3						
4	<b>REGION BETA</b>					
5						
6						
7		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8						
9	Contractor's Aggregate Resource	\$12,855,323	\$12,446,990	\$13,162,671	\$13,999,121	\$14,854,106
10	Sharing Expenditures Assumed in BAFO					
11						
12						
13	Sum of Projected Resource Sharing	\$13,000,000	\$0	\$0	\$0	\$0
14	Expenditures for Agreements Already					
15	Approved--To Be Supplied by Lead Agent					
16						
17						
18	Is Proposed Resource Sharing	NO	YES	YES	YES	YES
19	Agreement Already Included in					
20	the Contractor's Aggregate BAFO					
21	Spending Assumptions?					
22						

	A	B	C	D	E
1	RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET				
2	REGION BETA				
3					
4					
5	I.	Assumed Resource Savings Already Reflected in Proposed Bid Price Assumptions			
6					
7					
8	A.	Expected Contractor Category 8 Expenditures for CHAMPUS Eligibles Under This Resource Sharing Agreement			\$95,000
9					
10	B.	Are Proposed Savings Already Included in Contractor's BAFO?			NO
11					
12	C.	Assumed Savings:Cost Ratio Used to Develop Resource Sharing Savings Trend Factor			N/A
13		in Original Bid Price for Categories 1-7			
14					
15	D.	Expected Savings in Cat. 1-7 for this Agreement, Consistent with Proposed Savings Trend Factor			N/A
16		and Assumed To Be Already Reflected in Original Bid Price for Categories 1-7			
17					
18	E.	Net CHAMPUS Savings Assumed To Be Already Reflected in Contractor's BAFO			\$0
19		(Categories 1-7 Savings Minus Category 8 Expenditures)			
20					

	A	B	C	D	E
23	II.	Impact of Cat. 1-7 Bid Price Adjustment for O Factor			
24					
25					
26		Note: O Factor calculations must be beneficiary-category specific.			
27			ADD	NADD	Total
28	A.	Bid Price Components Unaffected by RS Agreement:			
29					
30	1.	Number of CHAMPUS Eligibles in DCP (for the Region)	78,660	140,490	NA
31					
32	2.	Number of CHAMPUS Eligibles in Option Period (for the Region)	68,573	137,914	NA
33					
34	3.	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 1-3 Total in Option Period (for the Region)	\$259	\$194	NA
35					
36	4.	$[(M \times P \times Q) + (M \times R \times S) + (M \times T \times U)]$ for Categories 4-7 Total in Option Period (for the Region)	\$221	\$292	NA
37					
38	B.	Inpatient Resource Sharing Agreements: Calculation of O Factor Impact			
39					
40	1.	NAS % of DCP Inpatient Costs (Input for O Factor Formula, for the Region)	52%	27%	NA
41					
42	2.	Number of NAS-Equivalents in DCP (Input for O Factor Formula, for the Region)	4,812	3,681	NA
43					
44	3.	Number of NAS-Equivalents without the Resource Sharing Agreement in Option Period	3,143	4,622	NA
45		(Input for O Factor Formula, for the Region)			
46					
47	4.	Inpatient O Factor without this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA
48					
49	5.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
50		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
51		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
52		Provided in Section J, Attachment 13)			
53					
54	6.	Number of NAS-Equivalents with the Resource Sharing Agreement in Option Period, Before	3,143	4,622	NA
55		Contractor Workload Credit			
56					
57	7.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period	45%	45%	NA
58		(Pending Confirmation of Acceptable Worksheet Results)			
59					
60	8.	Number of NAS-Equivalents Credited to Resource Sharing Agreement in Option Period	0	0	NA
61					
62	9.	Number of NAS-Equivalents with the RS Agreement in Option Period, After Contractor Workload Credit	3,143	4,622	NA
63					
64	10.	Inpatient O Factor with this Resource Sharing Agreement in Option Period	0.869603544	1.075354362	NA

	A	B	C	D	E
66	C.	Outpatient Resource Sharing Agreements: Calculation of O Factor Impact			
67					
68	1.	CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)	222,499	415,332	NA
69					
70	2.	MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)	339,214	650,449	NA
71					
72	3.	Number of MTF Outpatient Visits without the Resource Sharing Agreement in Option Period	237,505	408,955	NA
73		(Input for O Factor Formula, for the Region)			
74					
75	4.	Volume Trade-Off Factor for Outpatient Visits Assumed in Contract	1.8	2.8	
76					
77	5.	Outpatient O Factor without this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
78					
79	6.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	525	300	NA
80		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
81		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
82		Provided in Section J, Attachment 13)			
83					
84	7.	Number of MTF Outpatient Visits with the Resource Sharing Agreement in Option Period, Before	238,030	409,255	NA
85		Contractor Workload Credit			
86					
87	8.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period	45%	45%	NA
88		(Pending Confirmation of Acceptable Worksheet Results)			
89					
90	9.	Number of MTF Outpatient Visits Credited to Resource Sharing Agreement in Option Period	236	135	NA
91					
92	10.	Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit	237,794	409,120	NA
93					
94	11.	Outpatient O Factor with this Resource Sharing Agreement in Option Period	1.165896115	1.200947100	NA
95					
96	D.	Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any			
97					
98	1.	Inpatient CHAMPUS Costs (Categories 1 to 3)	\$0	\$0	\$0
99					
100	2.	Outpatient CHAMPUS Costs (Categories 4 to 7)	\$12,519	\$5,818	\$18,337
101					
102	3.	Total Change (Categories 1 to 7)	\$12,519	\$5,818	\$18,337
103					

	A	B	C	D	E
105	III.	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
111		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
112		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
113		Provided in Section J, Attachment 13)			
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	0	0	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$0	\$0	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$0	\$0	\$0
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	525	300	NA
126		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
127		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
128		Provided in Section J, Attachment 13)			
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.5	1.5	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	350	200	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$225	\$225	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$78,750	\$45,000	\$123,750
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$78,750	\$45,000	\$123,750
139					

	A	B	C	D	E
142	IV.	Risk Sharing Impact			
143					
144					
145	A.	Contractor's Resource Sharing Expenditures in Category 8 (For CHAMPUS Eligibles Only)			\$95,000
146					
147	B.	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Category 8 Costs)			\$28,750
148					
149	C.	Net Decrease in CHAMPUS Costs Already Reflected in Contractor's Total Bid Price			\$0
150		(Includes Effect of Assumed Resource Sharing Expenditures and Savings Trend Factor from BAFO)			
151					
152	D.	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any			\$18,337
153					
154	E.	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared			\$10,413
155		(Actual Net Decrease in Health Care Costs - Savings in BAFO Price - O Factor Adjustment)			
156					
157	F.	Expected Government Risk Sharing Responsibility Percentage			80%
158		(Lead Agent To Provide Guidance with Input from Contractor			
159		for This Assumption to Ensure Consistency within the Region)			
160					
161	G.	Expected Contractor Risk Sharing Responsibility Percentage			20%
162		(Lead Agent To Provide Guidance with Input from Contractor			
163		for This Assumption to Ensure Consistency within the Region)			
164					
165	H.	Resulting Government Gain Sharing Amount			\$8,330
166					
167	I.	Resulting Contractor Gain Sharing Amount			\$2,083
168					

	A	B	C	D	E
171	V.	<b>RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS</b>			
172					
173					
174	A.	Contractor Resource Sharing Workload Credit Assumed in Analysis (Above)			45%
175					
176	B.	Contractor's Resource Sharing Expenditures as Percent of Total Expenditures (Contractor + MTF Marginal)			98%
177		(For Information; Not Used in Worksheet Calculations)			
178					
179	C.	Analysis of Contractor Profit and Workload Credit:			
180					
181	1.	Contractor's Resource Sharing Expenditures			\$95,000
182		Are These Expenditures and the Resulting Savings Already Reflected in the Contractor's BAFO?			NO
183					
184	2.	Projected Actual Net Contractor Gain from Resource Sharing (Risk Sharing Result):			\$2,083
185		For Comparison in Judging Reasonable Workload Credit, vs. Profit Rate on Expenditures Only			
186		See Also Comparison of Contractor vs. Government Gains Under RS Agreement (Below)			
187					
188	3.	Projected Actual Contractor Resource Sharing Profit as Percent of Resource Sharing Expenditures			2.19%
189					
190	4.	Proposed Profit Rate for Overall Health Care Costs (from Contractor's BAFO)			3.50%
191					
192	5.	<b>Is Proposed Contractor Workload Credit Appropriate?</b>			<b>YES</b>
193		For Agreements Reflecting Expenditures and Resulting Savings Already Included in the Contractor's BAFO (See Part V.C.1),			(See Explanation at Left)
194		100 Percent Workload Credit is Appropriate If the MHSS Cost-Effectiveness Requirement Is Also Satisfied. For Agreements			
195		Reflecting Expenditures and Resulting Savings Beyond Those Assumed in the Contractor's BAFO, the Projected Actual			
196		Contractor Profit Rate for Resource Sharing (See Part V.C.3) Should Be Approximately Equal to the Proposed Profit Rate			
197		for Overall Health Care Costs (Rounding to the Nearest Full Percentage Point) (See Part V.C.4)			
198					
199	D.	Analysis of Cost-Effectiveness for the Government from the MHSS Perspective			
200					
201	1.	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)			\$1,500
202					
203	2.	Projected Government Gain in CHAMPUS Under RS Agreement (Net Savings in BAFO Price +			\$26,667
204		Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)			
205					
206	3.	Net Government MHSS Savings Under RS Agreement			\$25,167
207					
208	4.	<b>Do Government Gains Exceed Government Expenditures?</b>			<b>YES</b>
209		If the Result in Part V.D.3 Is a Positive Value, Then Government Gains Exceed Government Costs			
210					
211	E.	Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement			
212					
213	1.	Total Projected Net Contractor Gain Under Resource Sharing Agreement			\$2,083
214					
215	2.	Total Projected Net Government Gain Under Resource Sharing Agreement			\$25,167
216					
217		NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO PART V.C.5 AND V.D.4 ARE BOTH "YES."			
218		IF THE RESPONSES TO BOTH QUESTIONS (PARTS V.C.5 AND V.D.4) ARE NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD			
219		CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.			
220		IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR,			
221		THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE			
222		PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).			



**APPENDIX E. FAW FOR PARTNERSHIP CONVERSION RSA**

	A	B	C	D	E	F
1	<b>DETERMINING WHETHER THE PROPOSED RESOURCE SHARING EXPENDITURES ARE ALREADY INCLUDED IN THE CONTRACTOR'S AGGREGATE BAFO SPENDING ASSUMPTION</b>					
2						
3						
4	<b>REGION GAMMA</b>					
5						
6						
7		OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
8						
9	Contractor's Aggregate Resource	\$12,855,323	\$12,446,990	\$13,162,671	\$13,999,121	\$14,854,106
10	Sharing Expenditures Assumed in BAFO					
11						
12						
13	Sum of Projected Resource Sharing	\$1,500,000	\$0	\$0	\$0	\$0
14	Expenditures for Agreements Already					
15	Approved--To Be Supplied by Lead Agent					
16						
17						
18	Is Proposed Resource Sharing	YES	YES	YES	YES	YES
19	Agreement Already Included in					
20	the Contractor's Aggregate BAFO					
21	Spending Assumptions?					
22						

	A	B	C	D	E
1	<b>RESOURCE SHARING FINANCIAL ANALYSIS WORKSHEET</b>				
2	<b>REGION GAMMA</b>				
3					
4					
5	I.	<b>Assumed Resource Savings Already Reflected in Proposed Bid Price Assumptions</b>			
6					
7					
8	A.	Expected Contractor Category 8 Expenditures for CHAMPUS Eligibles Under This Resource Sharing Agreement			\$325,000
9					
10	B.	Are Proposed Savings Already Included in Contractor's BAFO?			YES
11					
12	C.	Assumed Savings:Cost Ratio Used to Develop Resource Sharing Savings Trend Factor			2.2
13		in Original Bid Price for Categories 1-7			
14					
15	D.	Expected Savings in Cat. 1-7 for this Agreement, Consistent with Proposed Savings Trend Factor			\$715,000
16		and Assumed To Be Already Reflected in Original Bid Price for Categories 1-7			
17					
18	E.	Net CHAMPUS Savings Assumed To Be Already Reflected in Contractor's BAFO			\$390,000
19		(Categories 1-7 Savings Minus Category 8 Expenditures)			
20					

	A	B	C	D	E
105	III.	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
111		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
112		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
113		Provided in Section J, Attachment 13)			
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	0	0	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$0	\$0	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$0	\$0	\$0
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	8,000	14,500	NA
126		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
127		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
128		Provided in Section J, Attachment 13)			
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.1	1.1	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	7,273	13,182	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$35	\$35	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$254,545	\$461,364	\$715,909
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$254,545	\$461,364	\$715,909
139					

	A	B	C	D	E
66	C.	Outpatient Resource Sharing Agreements: Calculation of O Factor Impact			
67					
68	1.	CHAMPUS Outpatient Visits in the DCP (Input for O Factor Formula, for the Region)	222,499	415,332	NA
69					
70	2.	MTF Outpatient Visits in DCP (Input for O Factor Formula, for the Region)	339,214	650,449	NA
71					
72	3.	Number of MTF Outpatient Visits without the Resource Sharing Agreement in Option Period	237,505	408,955	NA
73		(Input for O Factor Formula, for the Region)			
74					
75	4.	Volume Trade-Off Factor for Outpatient Visits Assumed in Contract	1.8	2.8	
76					
77	5.	Outpatient O Factor without this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
78					
79	6.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	8,000	14,500	NA
80		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
81		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
82		Provided in Section J, Attachment 13)			
83					
84	7.	Number of MTF Outpatient Visits with the Resource Sharing Agreement in Option Period, Before	245,505	423,455	NA
85		Contractor Workload Credit			
86					
87	8.	Contractor's Workload Credit for the Resource Sharing Agreement in Option Period	100%	100%	NA
88		(Pending Confirmation of Acceptable Worksheet Results)			
89					
90	9.	Number of MTF Outpatient Visits Credited to Resource Sharing Agreement in Option Period	8,000	14,500	NA
91					
92	10.	Number of MTF Outpatient Visits with the RS Agreement in Option Period, After Workload Credit	237,505	408,955	NA
93					
94	11.	Outpatient O Factor with this Resource Sharing Agreement in Option Period	1.166723147	1.201091634	NA
95					
96	D.	Decrease in Cat. 1-7 Bid Price due to O Factor Adjustment, If Any			
97					
98	1.	Inpatient CHAMPUS Costs (Categories 1 to 3)	\$0	\$0	\$0
99					
100	2.	Outpatient CHAMPUS Costs (Categories 4 to 7)	\$0	\$0	\$0
101					
102	3.	Total Change (Categories 1 to 7)	\$0	\$0	\$0
103					

	A	B	C	D	E
105	III.	Impact on Actual Cat. 1-7 CHAMPUS Claims Costs			
106					
107					
108	A.	Impact on Inpatient CHAMPUS Claims Costs	ADD	NADD	Total
109					
110	1.	Number of MTF Admissions of CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in Opti	0	0	NA
111		Period (Should Reflect the Number of MTF Admissions Which Would Not Occur in the Absence of the			
112		Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
113		Provided in Section J, Attachment 13)			
114					
115	2.	Assumed VTF for Inpatient Resource Sharing Workload Expected Under this Agreement	1.0	1.0	NA
116					
117	3.	Number of Admissions Avoided in CHAMPUS	0	0	NA
118					
119	4.	Average Government Cost Per Unit for Admissions Avoided in CHAMPUS	\$0	\$0	NA
120					
121	5.	Estimated Categories 1-3 Inpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$0	\$0	\$0
122					
123	B.	Impact on Outpatient CHAMPUS Claims Costs	ADD	NADD	Total
124					
125	1.	Number of MTF Outpatient Visits By CHAMPUS Eligibles Enabled by the Resource Sharing Agreement in	8,000	14,500	NA
126		Option Period (Should Reflect the Number of MTF Outpatient Visits Which Would Not Occur in the Absence			
127		of the Resource Sharing Agreement, According to the Resource Sharing Workload Reporting Guidelines			
128		Provided in Section J, Attachment 13)			
129					
130	2.	Assumed VTF for Outpatient Resource Sharing Workload Expected Under this Agreement	1.1	1.1	NA
131					
132	3.	Number of Outpatient Visits Avoided in CHAMPUS	7,273	13,182	NA
133					
134	4.	Average Government Cost Per Unit for Outpatient Visits Avoided in CHAMPUS	\$35	\$35	NA
135					
136	5.	Estimated Categories 4-7 Outpatient CHAMPUS Costs Avoided with Resource Sharing Agreement	\$254,545	\$461,364	\$715,909
137					
138	C.	Estimated Categories 1-7 CHAMPUS Costs Avoided with Resource Sharing Agreement	\$254,545	\$461,364	\$715,909
139					

	A	B	C	D	E
142	IV.	Risk Sharing Impact			
143					
144					
145	A.	Contractor's Resource Sharing Expenditures in Category 8 (For CHAMPUS Eligibles Only)			\$325,000
146					
147	B.	Net Decrease in Actual CHAMPUS Costs (Categories 1-7 Costs Avoided Minus Category 8 Costs)			\$390,909
148					
149	C.	Net Decrease in CHAMPUS Costs Already Reflected in Contractor's Total Bid Price			\$390,000
150		(Includes Effect of Assumed Resource Sharing Expenditures and Savings Trend Factor from BAFO)			
151					
152	D.	Decrease in Categories 1-7 Bid Price due to O Factor Adjustment, If Any			\$0
153					
154	E.	Residual Gain in CHAMPUS Categories 1-7 Costs To Be Shared			\$909
155		(Actual Net Decrease in Health Care Costs - Savings in BAFO Price - O Factor Adjustment)			
156					
157	F.	Expected Government Risk Sharing Responsibility Percentage			80%
158		(Lead Agent To Provide Guidance with Input from Contractor			
159		for This Assumption to Ensure Consistency within the Region)			
160					
161	G.	Expected Contractor Risk Sharing Responsibility Percentage			20%
162		(Lead Agent To Provide Guidance with Input from Contractor			
163		for This Assumption to Ensure Consistency within the Region)			
164					
165	H.	Resulting Government Gain Sharing Amount			\$727
166					
167	I.	Resulting Contractor Gain Sharing Amount			\$182
168					

	A	B	C	D	E
171	V.	RESULTS OF ANALYSIS: CHECK OF CONTRACTOR WORKLOAD CREDIT AND MHSS COST-EFFECTIVENESS			
172					
173					
174	A.	Contractor Resource Sharing Workload Credit Assumed in Analysis (Above)			100%
175					
176	B.	Contractor's Resource Sharing Expenditures as Percent of Total Expenditures (Contractor + MTF Marginal)			72%
177		(For Information; Not Used in Worksheet Calculations)			
178					
179	C.	Analysis of Contractor Profit and Workload Credit:			
180					
181	1.	Contractor's Resource Sharing Expenditures			\$325,000
182		Are These Expenditures and the Resulting Savings Already Reflected in the Contractor's BAFO?			YES
183					
184	2.	Projected Actual Net Contractor Gain from Resource Sharing (Risk Sharing Result):			\$182
185		For Comparison in Judging Reasonable Workload Credit, vs. Profit Rate on Expenditures Only			
186		See Also Comparison of Contractor vs. Government Gains Under RS Agreement (Below)			
187					
188	3.	Projected Actual Contractor Resource Sharing Profit as Percent of Resource Sharing Expenditures			0.06%
189					
190	4.	Proposed Profit Rate for Overall Health Care Costs (from Contractor's BAFO)			3.50%
191					
192	5.	<b>Is Proposed Contractor Workload Credit Appropriate?</b>			<b>YES</b>
193		For Agreements Reflecting Expenditures and Resulting Savings Already Included in the Contractor's BAFO (See Part V.C.1),		(See Explanation at Left)	
194		100 Percent Workload Credit is Appropriate If the MHSS Cost-Effectiveness Requirement is Also Satisfied. For Agreements			
195		Reflecting Expenditures and Resulting Savings Beyond Those Assumed in the Contractor's BAFO, the Projected Actual			
196		Contractor Profit Rate for Resource Sharing (See Part V.C.3) Should Be Approximately Equal to the Proposed Profit Rate			
197		for Overall Health Care Costs (Rounding to the Nearest Full Percentage Point) (See Part V.C.4)			
198					
199	D.	Analysis of Cost-Effectiveness for the Government from the MHSS Perspective			
200					
201	1.	Projected MTF Expenditures Under RS Agreement (For CHAMPUS Eligibles Only)			\$125,000
202					
203	2.	Projected Government Gain in CHAMPUS Under RS Agreement (Net Savings in BAFO Price +			\$390,727
204		Savings from O Factor Adjustment + Government Share of Residual CHAMPUS Gain)			
205					
206	3.	Net Government MHSS Savings Under RS Agreement			\$265,727
207					
208	4.	<b>Do Government Gains Exceed Government Expenditures?</b>			<b>YES</b>
209		If the Result in Part V.D.3 Is a Positive Value, Then Government Gains Exceed Government Costs			
210					
211	E.	Bottom Line Comparison of Projected Contractor and Government Gains Under RS Agreement			
212					
213	1.	Total Projected Net Contractor Gain Under Resource Sharing Agreement			\$182
214					
215	2.	Total Projected Net Government Gain Under Resource Sharing Agreement			\$265,727
216					
217		NOTE: TERMS OF PROPOSED AGREEMENT SHOULD ONLY BE APPROVED IF THE RESPONSES TO PART V.C.5 AND V.D.4 ARE BOTH "YES."			
218		IF THE RESPONSES TO BOTH QUESTIONS (PARTS V.C.5 AND V.D.4) ARE NOT "YES," THEN THE PROPOSED CONTRACTOR WORKLOAD			
219		CREDIT SHOULD BE ADJUSTED ON AN ITERATIVE BASIS UNTIL THE PROPOSED AGREEMENT SATISFIES BOTH REQUIREMENTS.			
220		IF THIS IS NOT POSSIBLE, GIVEN ALL OF THE OTHER INPUT ASSUMPTIONS AGREED UPON BY THE MTF COMMANDER AND THE CONTRACTOR,			
221		THEN THE PROPOSED RESOURCE SHARING AGREEMENT SHOULD NOT BE APPROVED (UNLESS THE LEAD AGENT DETERMINES THAT THE			
222		PROPOSED AGREEMENT STILL WARRANTS APPROVAL DUE TO COMPELLING CIRCUMSTANCES).			



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